

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0049775</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Helia Healthcare of Benton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1310 M F Louis St</u> <u>Benton</u> <u>62812</u>																									
Number City Zip Code																									
County: <u>Franklin</u>																									
Telephone Number: <u>(618) 932-3236</u> Fax # <u>(618) 937-1171</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jason Mills</u></td></tr><tr><td>(Title) <u>Director of Corporate Accounting and IT Systems</u></td></tr><tr><td>(Signed) <u>See Accountant's Preparation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cindy Tefteller</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E Center Drive, Alton, IL 62002</u></td></tr><tr><td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jason Mills</u>	(Title) <u>Director of Corporate Accounting and IT Systems</u>	(Signed) <u>See Accountant's Preparation Report</u>	Paid Preparer	(Print Name and Title) <u>Cindy Tefteller</u> <u>Partner</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E Center Drive, Alton, IL 62002</u>	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>8/15/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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In the event there are further questions about this report, please contact:																									
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>83</u>	Skilled (SNF)	<u>83</u>	<u>30,378</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>83</u>	TOTALS	<u>83</u>	<u>30,378</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,704</u>	<u>6,260</u>	<u>5,409</u>	<u>26,373</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,704</u>	<u>6,260</u>	<u>5,409</u>	<u>26,373</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.82%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 08/15/08

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/15/08 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 83 and days of care provided 4,633

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Helia Healthcare of Benton** # **0049775** Report Period Beginning: **01/01/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	106,415	18,360	153,769	278,544		278,544		278,544			1
2	Food Purchase		273,942		273,942		273,942	(322)	273,620			2
3	Housekeeping	123,430	42,914	1,163	167,507		167,507		167,507			3
4	Laundry	15,688	17,680	72,450	105,818		105,818	(10,257)	95,561			4
5	Heat and Other Utilities			89,913	89,913		89,913	563	90,476			5
6	Maintenance	18,181	29,260	34,788	82,229		82,229	21,416	103,645			6
7	Other (specify):*											7
8	TOTAL General Services	263,714	382,156	352,083	997,953		997,953	11,400	1,009,353			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,207,951	103,926	23,525	1,335,402		1,335,402	13,418	1,348,820			10
10a	Therapy		9		9		9		9			10a
11	Activities	35,553	15,622	3,549	54,724		54,724	(3,265)	51,459			11
12	Social Services	38,409		1,308	39,717		39,717		39,717			12
13	CNA Training											13
14	Program Transportation			1,120	1,120		1,120		1,120			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,281,913	119,557	41,502	1,442,972		1,442,972	10,153	1,453,125			16
	C. General Administration											
17	Administrative	78,132		255,000	333,132		333,132	(229,239)	103,893			17
18	Directors Fees											18
19	Professional Services			20,606	20,606		20,606	5,094	25,700			19
20	Dues, Fees, Subscriptions & Promotions			72,282	72,282		72,282	(50,141)	22,141			20
21	Clerical & General Office Expenses	83,316	24,311	97,403	205,030		205,030	138,734	343,764			21
22	Employee Benefits & Payroll Taxes			255,720	255,720		255,720	39,798	295,518			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,859	2,859		2,859	4,940	7,799			24
25	Other Admin. Staff Transportation			6,086	6,086		6,086	21,619	27,705			25
26	Insurance-Prop.Liab.Malpractice			73,050	73,050		73,050	4,451	77,501			26
27	Other (specify):*											27
28	TOTAL General Administration	161,448	24,311	783,006	968,765		968,765	(64,744)	904,021			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,707,075	526,024	1,176,591	3,409,690		3,409,690	(43,191)	3,366,499			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			21,391	21,391		21,391	13,223	34,614			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,671	43,671		43,671	(1,933)	41,738			32
33	Real Estate Taxes			21,000	21,000		21,000	(20,248)	752			33
34	Rent-Facility & Grounds			305,795	305,795		305,795	(286,816)	18,979			34
35	Rent-Equipment & Vehicles			33,466	33,466		33,466	(2,538)	30,928			35
36	Other (specify):*											36
37	TOTAL Ownership			425,323	425,323		425,323	(298,312)	127,011			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,970	588,058	800,028		800,028		800,028			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,333	161,333		161,333		161,333			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		211,970	749,391	961,361		961,361		961,361			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,707,075	737,994	2,351,305	4,796,374		4,796,374	(341,503)	4,454,871			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,265)	11		4
5	Telephone, TV & Radio in Resident Rooms	(5,313)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,933)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(322)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(610)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,354)	21		19
20	Contributions	(477)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(40,271)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,905)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,450)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(276,053)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (276,053)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (341,503)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	\$ (7,469)	20	1
2	Eliminate Lobbying & PAC Dues	(2,381)	20	2
3	Eliminate Medical Record Copies	(55)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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25				25
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,905)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(322)	0	0	0	0	0	0	0	0	0	0	(322)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(10,257)	0	0	0	0	0	0	0	0	(10,257)	4
5	Heat and Other Utilities	(5,313)	183	5,693	0	0	0	0	0	0	0	0	563	5
6	Maintenance	0	0	21,416	0	0	0	0	0	0	0	0	21,416	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,635)	183	16,852	0	0	0	0	0	0	0	0	11,400	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(55)	13,473	0	0	0	0	0	0	0	0	0	13,418	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,265)	0	0	0	0	0	0	0	0	0	0	(3,265)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,320)	13,473	0	0	0	0	0	0	0	0	0	10,153	16
	C. General Administration													
17	Administrative	0	(229,239)	0	0	0	0	0	0	0	0	0	(229,239)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,147	947	0	0	0	0	0	0	0	0	5,094	19
20	Fees, Subscriptions & Promotions	(50,731)	590	0	0	0	0	0	0	0	0	0	(50,141)	20
21	Clerical & General Office Expenses	(3,831)	139,726	2,839	0	0	0	0	0	0	0	0	138,734	21
22	Employee Benefits & Payroll Taxes	0	21,309	18,489	0	0	0	0	0	0	0	0	39,798	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,940	0	0	0	0	0	0	0	0	0	4,940	24
25	Other Admin. Staff Transportation	0	6,340	15,279	0	0	0	0	0	0	0	0	21,619	25
26	Insurance-Prop.Liab.Malpractice	0	1,012	3,439	0	0	0	0	0	0	0	0	4,451	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(54,562)	(51,175)	40,993	0	0	0	0	0	0	0	0	(64,744)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(63,517)	(37,519)	57,845	0	0	0	0	0	0	0	0	(43,191)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	1,708	11,515	0	0	0	0	0	0	0	0	13,223	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,933)	0	0	0	0	0	0	0	0	0	0	(1,933)	32
33	Real Estate Taxes	0	19	(20,267)	0	0	0	0	0	0	0	0	(20,248)	33
34	Rent-Facility & Grounds	0	7,895	(294,711)	0	0	0	0	0	0	0	0	(286,816)	34
35	Rent-Equipment & Vehicles	0	0	(2,538)	0	0	0	0	0	0	0	0	(2,538)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,933)	9,622	(306,001)	0	0	0	0	0	0	0	0	(298,312)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(65,450)	(27,897)	(248,156)	0	0	0	0	0	0	0	0	(341,503)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthare of Greenville	Greenville	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 183	\$ 183	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	13,473	13,473	2
3	V	17	Management Fees	255,000	Bridgemark Healthcare, LLC	100.00%	25,761	(229,239)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	4,147	4,147	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	590	590	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	139,726	139,726	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	21,309	21,309	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,940	4,940	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	6,340	6,340	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,012	1,012	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,708	1,708	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	19	19	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,895	7,895	13
14	Total			\$ 255,000			\$ 227,103	\$ * (27,897)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 783	\$ 783	15
16	V								16
17	V	21	Clerical & Office Supplies		Bridgemark Medical Supply	100.00%	5	5	17
18	V	30	Depreciation		Bridgemark Medical Supply	100.00%	482	482	18
19	V	34	Building Rent		Bridgemark Medical Supply	100.00%	185	185	19
20	V	35	Equipment Rental	3,321	Bridgemark Medical Supply	100.00%		(3,321)	20
21	V								21
22	V	4	Laundry	49,200	Helia Healthcare Services	100.00%	38,943	(10,257)	22
23	V	5	Utilities		Helia Healthcare Services	100.00%	5,693	5,693	23
24	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	24,416	21,416	24
25	V	19	Professional Services		Helia Healthcare Services	100.00%	947	947	25
26	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	2,834	2,834	26
27	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	18,489	18,489	27
28	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	15,279	15,279	28
29	V	26	Insurance		Helia Healthcare Services	100.00%	3,439	3,439	29
30	V	30	Depreciation		Helia Healthcare Services	100.00%	2,792	2,792	30
31	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	733	733	31
32	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	3,054	3,054	32
33	V								33
34	V	30	Depreciation		BM Properties I - Benton	100.00%	8,241	8,241	34
35	V	33	Real Estate Taxes	21,000	BM Properties I - Benton	100.00%		(21,000)	35
36	V	34	Rent - Facility & Grounds	302,950	BM Properties I - Benton	100.00%	5,000	(297,950)	36
37	V								37
38	V								38
39	Total			\$ 379,471			\$ 131,315	\$ * (248,156)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Jerseyville	Jerseyville, IL				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	335,782	3.56	7.13	Distribution	\$ 25,761	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,761		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 12/31/16

((314) 754-9176

Ending: 12/31/16

()

Ending: 12/31/16

()

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09					Variable	43,671	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 43,671	9
	B. Non-Facility Related*												
10	Interest Income Offset		X									(1,933)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (1,933)	14
15	TOTALS (line 9+line14)						\$					\$ 41,738	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

[illegible]

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation**. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

39,067

B. General Construction Type:

Exterior Brick Masonary

Frame Metal

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Related Party Allocation - Helia Healthcare			\$ 2,257	1
2					2
3	TOTALS			\$ 2,257	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Helia Healthcare Allocation		2006		\$ 60,155	\$	25	\$ 1,061	\$ 1,061	\$ 7,661	4
5	83		2008		134,098		30	4,470	4,470	37,622	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		643	9
10	Exterior Sign			2009	5,265	527	10	527		4,125	10
11	Wallcovering for hallways & entranceway, door, shower remodel			2009	11,252	750	15	750		5,501	11
12	Carpet			2009	1,170		5			1,170	12
13	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		1,234	13
14	New Pipes, Install Eye Wash			2010	2,215	89	25	89		585	14
15	AC, Fans, dehumidifier			2010	1,609	161	10	161		1,046	15
16	Outside singe door & frame			2010	4,168	278	15	278		1,737	16
17	Shower room - tile, shower heads, electrical work, fixtures, paint			2011	3,860	257	15	257		1,435	17
18	Dinette/Common area remodel - doors, windows, counters, cabinetry										18
19	(cont.) flooring, electrical, plywood, paint			2011	13,693	913	15	913		5,098	19
20	Back-up generator			2011	12,864	643	20	643		3,430	20
21	Sprinkler System			2012	97,800	3,912	25	3,912		19,560	21
22	Fire doors			2012	9,942	663	15	663		3,204	22
23	Oxygen Shed			2012	1,941	194	10	194		857	23
24	AC Equipment North Hallway			2014	1,896	190	10	190		475	24
25	Painting 1 room, 1/2 North Hall			2014	250	50	5	50		108	25
26	Therapy Remodel - flooring, painting, & lighting			2015	4,045	270	15	270		449	26
27	Vinyl Sliding Door & Installation			2015	5,325	355	15	355		503	27
28	Flooring in North hall rooms and hallway			2015	7,282	485	15	485		647	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Related Party Allocation - Bridgemark Healthcare LLC		\$	\$		\$	\$	\$	37
38 New Office Build-Out	2011	9,677		20	513	513	2,795	38
39 Conference Room Chair Rail & Paint	2012	109		5	22	22	95	39
40								40
41								41
42 Related Party Allocation - Helia Healthcare								42
43 Water & Sewer Pipe Installation	2006	856		20	43	43	446	43
44 Plumbing & Heating Installation	2006	1,025		20	51	51	534	44
45 A/C Unit - 4 Ton	2007	2,469		10	247	247	2,386	45
46 400 Gal. Water Storage Tank	2016	6,966		10	290	290	290	46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 403,709	\$ 9,988		\$ 16,685	\$ 6,697	\$ 103,636	70

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$143,545	\$10,177	\$15,914	\$5,737	3-15	\$80,961	71
72	Current Year Purchases	31,773	1,226	2,015	789	3-15	2,015	72
73	Fully Depreciated Assets	35,273					35,273	73
74								74
75	TOTALS	\$210,591	\$11,403	\$17,929	\$6,526		\$118,249	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2011	\$28,821	\$	\$	\$	4	\$28,821	76
77	Related Party Allocation - Bridgemark		2005	947				4	947	77
78	Related Party Allocation - Helia		2006	3,024				4	3,024	78
79										79
80	TOTALS			\$32,792	\$	\$	\$		\$32,792	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$649,349	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$21,391	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$34,614	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$13,223	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$254,677	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Section N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Rental				2,845			5
6	Related Party Allocation				16,134			6
7	TOTAL				\$ 18,979			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the leaseN/A.
- N/A

9. Option to Buy:☐ YES☒ X NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ X NO
16. Rental Amount for movable equipment: \$ 30,928 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				9		9	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				170,049		170,049	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39,2					41,920		41,920	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3				588,058			588,058	13
14	TOTAL			\$		\$ 588,058	\$ 211,978		\$ 800,036	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,071	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 126,778)	1,164,571		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,153		7
8	Accounts Receivable (owners or related parties)	2,652,374		8
9	Other(specify): Deposits	100		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,840,269	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	188,354		15
16	Equipment, at Historical Cost	153,045		16
17	Accumulated Depreciation (book methods)	(136,597)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	42,000		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 246,802	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,087,071	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,055,750	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,625		30
31	Accrued Taxes Payable (excluding real estate taxes)	(822)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,877		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	9,710		36
37	Accrued Expenses	8,318		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,139,458	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	123,729		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 123,729	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,263,187	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,823,884	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,087,071	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,709,124	1
2	Restatements (describe):		2
3	Prior Year Adjustment to Accrued Property Taxes	19,100	3
4	Prior Year Adjustment to Workers Comp Audit	(156,849)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,571,375	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	252,509	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 252,509	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,823,884	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775

Report Period Beginning: 01/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,941,630	1
2	Discounts and Allowances for all Levels	(66,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,875,503	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,376	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,376	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,265	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,265	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,932	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,932	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	2,752	28
28a	Medical Record Copies	55	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,807	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,048,883	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	997,953	31
32	Health Care	1,442,972	32
33	General Administration	968,765	33
	B. Capital Expense		
34	Ownership	425,323	34
	C. Ancillary Expense		
35	Special Cost Centers	800,028	35
36	Provider Participation Fee	161,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,796,374	40
41	Income before Income Taxes (line 30 minus line 40)**	252,509	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 252,509	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,668,377	44
45	Private Pay - Net Inpatient Revenue	872,460	45
46	Medicare - Net Inpatient Revenue	2,094,844	46
47	Other-(specify) Insurance	223,109	47
48	Other-(specify) Hospice	16,713	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,875,503	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Filed Yet If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,018	2,142	\$ 69,301	\$ 32.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,002	12,810	328,134	25.62	3
4	Licensed Practical Nurses	11,125	12,131	247,415	20.40	4
5	CNAs & Orderlies	48,399	51,527	556,693	10.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,856	3,056	35,553	11.63	10
11	Social Service Workers	2,060	2,211	38,409	17.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,401	9,038	106,415	11.77	15
16	Dishwashers					16
17	Maintenance Workers	918	974	18,181	18.67	17
18	Housekeepers	10,512	11,244	123,430	10.98	18
19	Laundry	1,760	1,837	15,688	8.54	19
20	Administrator	1,892	2,094	78,132	37.31	20
21	Assistant Administrator					21
22	Other Administrative	1,165	1,260	34,362	27.27	22
23	Office Manager	2,056	2,274	48,954	21.53	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	269	740	6,408	8.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,433	113,338	\$ 1,707,075 *	\$ 15.06	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		2,317	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,232	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,549	11,3	44
45	Social Service Consultant		1,308	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,406		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	Section N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Loretta Ellis	Administrator	0	\$ 78,132
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,132
B. Administrative - Other			
Description			Amount
Bridgemark Healthcare LLC - Management Fees			\$ 255,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 255,000
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company, LLC	Accounting		\$ 3,775
Paycom Payroll, LLC	Payroll Processing		11,240
Personnel Planners, Inc.	Unemployment Consulting		1,682
Craig and Craig	Legal fees		3,425
Ashman & Stein	Legal fees		119
HK Payroll Services	WOTC Program		365
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 20,606
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 61,902
Unemployment Compensation Insurance			45,111
FICA Taxes			126,997
Employee Health Insurance			12,519
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401(k) Match			3,013
Employee Benefits			6,176
Other Employee Insurance			2
Related Party Allocation - Bridgemark			21,309
Related Party Allocation - Helia Healthcare			18,489
TOTAL (agree to Schedule V, line 22, col.8)			\$ 295,518
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
Section N/A			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			6,671
Health Care Worker Background Check (Indicate # of checks performed)			4,540
Patient Background Checks			
Dues & Subscriptions			6,203
Late Fees			2,066
Miscellaneous Liceneses & Fees			81
Advertising			40,271
Related Party Allocation - Bridgemark			590
Less: Public Relations Expense	(		)
Non-allowable advertising			(40,271)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,141
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			2,859
Related Party Allocation - Bridgemark			4,940
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 7,799

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name & ID Number Helia Healthcare of Benton	STATE OF ILLINOIS # 0049775	Report Period Beginning: 01/01/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. IHCA \$3,647

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 5-10 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,587 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 161,333
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,265

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

Description		
16A	Nursing Equipment	26,177
16B	Copier Lease	3,433
16C	Related Party Allocation - Bridgemark Healthcare	783
16D	Dietary Equipment	535
		<u>30,928</u>