FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0050757

Facility Name: Helia Healthcare of Olney

Address: 410 East Mack (Number) Olney (City) 62450 (Zip Code)

County: Richland

Telephone Number: (618) 395-7421 **Fax #** (618) 395-8210

HFS ID Number:

Date of Initial License for Current Owners: 04/30/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	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	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,422	2,514	5,301	25,237	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,422	2,514	5,301	25,237	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.60%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 4,604

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/15 Fiscal Year: 12/31/15

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	143,656	14,978	11,002	169,636		169,636		169,636			1
2	Food Purchase		167,047		167,047		167,047	(82)	166,965			2
3	Housekeeping	111,838	20,586	220	132,644		132,644		132,644			3
4	Laundry	38,115	16,888		55,003		55,003		55,003			4
5	Heat and Other Utilities			81,624	81,624		81,624	(11,058)	70,566			5
6	Maintenance	28,081	20,261	76,081	124,423		124,423		124,423			6
7	Other (specify):*											7
8	**TOTAL General Services**	321,690	239,760	168,927	730,377		730,377	(11,140)	719,237			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,192,166	103,492	31,242	1,326,900		1,326,900	13,302	1,340,202			10
10a	Therapy		330		330		330		330			10a
11	Activities	23,178	5,482	6,149	34,809		34,809	(425)	34,384			11
12	Social Services	34,476	68	2,322	36,866		36,866		36,866			12
13	CNA Training											13
14	Program Transportation			10,465	10,465		10,465		10,465			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,249,820	109,372	62,178	1,421,370		1,421,370	12,877	1,434,247			16
	C. General Administration											
17	Administrative	78,715		251,200	329,915		329,915	(228,415)	101,500			17
18	Directors Fees											18
19	Professional Services			18,678	18,678		18,678	5,472	24,150			19
20	Dues, Fees, Subscriptions & Promotions			89,427	89,427		89,427	(69,116)	20,311			20
21	Clerical & General Office Expenses	40,007	11,659	84,401	136,067		136,067	138,153	274,220			21
22	Employee Benefits & Payroll Taxes			281,905	281,905		281,905	26,337	308,242			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,172	5,172		5,172	5,054	10,226			24
25	Other Admin. Staff Transportation			3,150	3,150		3,150	7,456	10,606			25
26	Insurance-Prop.Liab.Malpractice			91,069	91,069		91,069	1,554	92,623			26
27	Other (specify):*											27
28	**TOTAL General Administration**	118,722	11,659	825,002	955,383		955,383	(113,505)	841,878			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,690,232	360,791	1,056,107	3,107,130		3,107,130	(111,768)	2,995,362			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Olney #0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,313	34,313		34,313	4,657	38,970			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			235,506	235,506		235,506	(1,137)	234,369			32
33	Real Estate Taxes			66,277	66,277		66,277	20	66,297			33
34	Rent-Facility & Grounds			711,005	711,005		711,005	8,429	719,434			34
35	Rent-Equipment & Vehicles			16,951	16,951		16,951	(12,695)	4,256			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,064,052	1,064,052		1,064,052	(726)	1,063,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,550	813,892	1,050,442		1,050,442		1,050,442			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,560	166,560		166,560		166,560			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		236,550	980,452	1,217,002		1,217,002		1,217,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,690,232	597,341	3,100,611	5,388,184		5,388,184	(112,494)	5,275,690			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(425)	11		4
5	Telephone, TV & Radio in Resident Rooms	(11,109)	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	(1,137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(82)	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	(500)	20		17
18	Fines and Penalties				18
19	Entertainment	(1,272)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(63,939)	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	(5,538)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (84,015)		$	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)	(28,479)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,479)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (112,494)		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' COMPILATION REPORT

Helia Healthcare of Olney

ID# 0050757

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (2,899)	20	1
2	Eliminate Lobbying & PAC Dues	(2,639)	20	2
3				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
24				24
25				25
26				26
27				27
28				28
29				29
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**	(5,538)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Olney # 0050757 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(82)	0	0	0	0	0	0	0	0	0	0	(82)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,109)	51	0	0	0	0	0	0	0	0	0	(11,058)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,191)	51	0	0	0	0	0	0	0	0	0	(11,140)	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	0	13,302	0	0	0	0	0	0	0	0	0	13,302	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(425)	0	0	0	0	0	0	0	0	0	0	(425)	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**	(425)	13,302	0	0	0	0	0	0	0	0	0	12,877	16
	C. General Administration													
17	Administrative	0	(228,415)	0	0	0	0	0	0	0	0	0	(228,415)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13)	5,485	0	0	0	0	0	0	0	0	0	5,472	19
20	Fees, Subscriptions & Promotions	(69,977)	861	0	0	0	0	0	0	0	0	0	(69,116)	20
21	Clerical & General Office Expenses	(1,272)	139,350	75	0	0	0	0	0	0	0	0	138,153	21
22	Employee Benefits & Payroll Taxes	0	26,337	0	0	0	0	0	0	0	0	0	26,337	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,054	0	0	0	0	0	0	0	0	0	5,054	24
25	Other Admin. Staff Transportation	0	7,456	0	0	0	0	0	0	0	0	0	7,456	25
26	Insurance-Prop.Liab.Malpractice	0	1,554	0	0	0	0	0	0	0	0	0	1,554	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(71,262)	(42,318)	75	0	0	0	0	0	0	0	0	(113,505)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(82,878)	(28,965)	75	0	0	0	0	0	0	0	0	(111,768)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Olney **#** 0050757 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	2,365	2,292	0	0	0	0	0	0	0	0	4,657	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,137)	0	0	0	0	0	0	0	0	0	0	(1,137)	32
33	Real Estate Taxes	0	20	0	0	0	0	0	0	0	0	0	20	33
34	Rent-Facility & Grounds	0	7,736	693	0	0	0	0	0	0	0	0	8,429	34
35	Rent-Equipment & Vehicles	0	0	(12,695)	0	0	0	0	0	0	0	0	(12,695)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,137)	10,121	(9,710)	0	0	0	0	0	0	0	0	(726)	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)**	(84,015)	(18,844)	(9,635)	0	0	0	0	0	0	0	0	(112,494)	45

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Benton	Benton, 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 Belleville	Belleville, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthcare of Greenville	Greenville, IL	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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 51	$ 51	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	13,302	13,302	2
3	V	17	Management Fees	251,200	Bridgemark Healthcare, LLC	100.00%	22,785	(228,415)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	5,485	5,485	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	861	861	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	139,350	139,350	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	26,337	26,337	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,054	5,054	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	7,456	7,456	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,554	1,554	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,365	2,365	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	20	20	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,736	7,736	13
14	Total			$ 251,200			$ 232,356	$ * (18,844)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & Office Supplies	$	Bridgemark Medical Supply	100.00%	$ 75	$ 75	15
16	V	30	Depreciation		Bridgemark Medical Supply	100.00%	2,292	2,292	16
17	V	34	Building Rent		Bridgemark Medical Supply	100.00%	693	693	17
18	V	35	Equipment Rental	13,322	Bridgemark Medical Supply	100.00%		(13,322)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	627	627	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,322			$ 3,687	$ * (9,635)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	277,215	3.8	7.59	Distribution	$ 22,785	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	$ 22,785		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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Bridgemark Healthcare, LLC
Street Address: 11970 Borman Drive, Suite 100
City / State / Zip Code: St. Louis, MO 63146
Phone Number: ((314) 431-0511
Fax Number: ((314) 754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	332,289	13	$ 671	$	25,237	$ 51	1
2	10	Nursing & Medical Records	Resident Days	332,289	13	175,140	175,140	25,237	13,302	2
3	17	Owners Compensation	Resident Days	332,289	13	300,000		25,237	22,785	3
4	19	Professional Fees	Resident Days	332,289	13	72,214		25,237	5,485	4
5	20	Dues, Subscriptions	Resident Days	332,289	13	11,333		25,237	861	5
6	21	Salaries - Other	Resident Days	332,289	13	1,491,031	1,491,031	25,237	113,242	6
7	21	Clerical & Office Supplies	Resident Days	332,289	13	343,761		25,237	26,108	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	332,289	13	346,778		25,237	26,337	8
9	24	Seminars	Resident Days	332,289	13	66,551		25,237	5,054	9
10	25	Admin Staff Travel	Resident Days	332,289	13	98,168		25,237	7,456	10
11	26	Insurance	Resident Days	332,289	13	20,457		25,237	1,554	11
12	30	Depreciation	Resident Days	332,289	13	31,136		25,237	2,365	12
13	33	Real Estate Taxes	Resident Days	332,289	13	263		25,237	20	13
14	34	Building Rent	Resident Days	332,289	13	94,122		25,237	7,148	14
15	34	Rental - Storage Unit	Resident Days	332,289	13	7,741		25,237	588	15
16	35	Equipment Rental	Resident Days	332,289	13	8,255		25,237	627	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,067,621	$ 1,666,171		$ 232,983	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Bridgemark Medical Supply
Street Address:
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & Office Supplies	Revenue	119,851	7	$ 679	$	13,322	$ 75	1
2	30	Depreciation	Revenue	119,851	7	20,624		13,322	2,292	2
3	34	Building Rent	Revenue	119,851	7	6,237		13,322	693	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
24										24
25	TOTALS					$ 27,540	$		$ 3,060	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	235,506	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 235,506	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(1,137)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,137)	14
15	TOTALS (line 9+line14)						$	$			$ 234,369	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' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 64,345	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (64,345)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 130,622	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 66,277	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	59,031	8
	2011	58,974	9
	2012	59,279	10
	2013	62,472	11
	2014	66,338	12

66,277 Line 7, Real Estate portion of Lease payment
20 Bridgemark Healthcare Allocation
66,297 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Olney COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0050757

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-27-450-002	Plat/Block/LotPT SW SE SE	$ 66,338.34	$ 66,338.34
2.		Unplatted 55	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,338.34	$ 66,338.34

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.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,034 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	20,000 Watt Generator			2010	8,067	134	5	134		8,067	9
10	Upgrade Existing Fire Alarm System			2010	16,191	1,619	10	1,619		9,445	10
11	Fire Alarm Panel & Fire doors			2011	20,209	1,954	10	1,954		8,909	11
12	A/C System improvements & New A/C units			2011	9,134	1,509	15	1,509		6,695	12
13	Signs			2012	7,427	743	10	743		2,352	13
14	AC Unit Replacement			2013	5,592	559	10	559		1,584	14
15	Toilets, Tubs, Lavatories, BR Fixtures - ARCH Unit			2013	5,259	263	20	263		789	15
16	Kitchen Cabinets, Countertops - ARCH Unit			2013	5,523	368	15	368		1,105	16
17	Doors ARCH unit			2013	10,320	688	15	688		2,064	17
18	Call System ARCH Unit			2013	1,026	103	10	103		308	18
19	Flooring ARCH Unit			2013	10,671	2,134	5	2,134		2,207	19
20	Curtains, Drapes, Blinds - ARCH Unit			2013	2,578	516	5	516		1,547	20
21	Pendent Sprinklers			2013	1,290	86	15	86		258	21
22	GE Door Alarm Keypad - ARCH Unit			2013	1,074	107	10	107		322	22
23	Dining/Bathroom Flooring - ARCH Unit			2013	4,255	426	10	426		1,277	23
24	HTG & AC for Shower Room - ARCH Unit			2013	682	136	10	136		409	24
25	Fireplace			2013	1,499	150	5	150		425	25
26	Tear out old walls & replace - ARCH Unit			2013	157,405	7,870	10	7,870		23,611	26
27	4 Frigidaire Heat/Cool Units			2014	2,503	250	10	250		438	27
28	Replace wter heater			2014	1,436	144	10	144		180	28
29	Schrey System			2014	1,792	179	10	179		224	29
30	CTS ran phone & data cable			2014	878	88	10	88		110	30
31	Redo all kitchen plumbing			2014	7,222	722	10	722		1,023	31
32	Frigidaire heat/cool unit			2014	1,259	252	5	252		357	32
33	Whisper Grove Hall - prep/paint/floor			2015	8,331	278	10	278		278	33
34	Read's Inc. - AC/Heat Unit			2015	5,806	1,064	5	1,064		1,064	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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									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	Related Party Allocation - Bridgemark HealthcareLLC								63
64	New Office Build-Out	2011	10,315		20	546	546	2,432	64
65	Conference Room Chair Rail & Paint	2012	117		5	23	23	78	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 307,861	$ 22,342		$ 22,911	$ 569	$ 77,558	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 132,083	$ 11,127	$ 15,186	$ 4,059	3-15	$ 58,219	71
72	Current Year Purchases	20,431	844	873	29	3-15	873	72
73	Fully Depreciated Assets	14,469					14,469	73
74								74
75	TOTALS	$ 166,983	$ 11,971	$ 16,059	$ 4,088		$ 73,561	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	2002 Ford E-450	2010	$ 3,407	$	$	$	4	$ 3,407	76
77	Related Party Allocation - Bridgemark			1,009				4	1,009	77
78										78
79										79
80	TOTALS			$ 4,416	$	$	$		$ 4,416	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)	$ 479,260	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,313	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,970	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,657	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 155,535	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CR Aviv, LLC
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 [X] 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:		118		$ 710,145			3
4	Additions							4
5	Related Party Allocations				8,429			5
6	Storage Rental				860			6
7	TOTAL		118		$ 719,434 **			7

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

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 4,256 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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] 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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	
	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				330		330	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				191,506		191,506	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					45,044		45,044	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				813,892			813,892	13
14	TOTAL			$		$ 813,892	$ 236,880		$ 1,050,772	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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,398	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 99,275)	906,931		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,085		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	134,249		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,063,663	$	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	300,105		15
16	Equipment, at Historical Cost	129,422		16
17	Accumulated Depreciation (book methods)	(128,903)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	130,624		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 431,248	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,494,911	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,231,788	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	(303)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	130,622		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	4,179,097		36
37	Accrued Provider Assessments	967		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,546,379	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,546,379	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,051,468)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,494,911	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,602,691)	1
2	Restatements (describe):		2
3	**Prior Year Adjustment for Workers Comp Audit**	38,814	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,563,877)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(487,591)	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)**	$ (487,591)	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)**	$ (4,051,468)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,718,189	1
2	Discounts and Allowances for all Levels	(119,435)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,598,754	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,384	6
7	Oxygen	1,324	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 296,708	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	425	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	42	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)**	$ 467	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,137	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,137	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	836	28
28a	Flu Shots	2,691	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,527	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,900,593	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	730,377	31
32	Health Care	1,421,370	32
33	General Administration	955,383	33
	B. Capital Expense		
34	Ownership	1,064,052	34
	C. Ancillary Expense		
35	Special Cost Centers	1,050,442	35
36	Provider Participation Fee	166,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,388,184	40
41	**Income before Income Taxes (line 30 minus line 40)****	(487,591)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (487,591)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,831,067	44
45	Private Pay - Net Inpatient Revenue	332,024	45
46	Medicare - Net Inpatient Revenue	2,183,350	46
47	Other-(specify) Insurance	238,675	47
48	Other-(specify) Hospice	13,637	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,598,754	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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,280	1,523	$ 49,303	$ 32.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,623	16,495	388,551	23.56	3
4	Licensed Practical Nurses	12,312	13,350	243,676	18.25	4
5	CNAs & Orderlies	40,002	42,938	506,270	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	257	289	4,366	15.11	8
9	Activity Director					9
10	Activity Assistants	1,736	1,893	23,178	12.24	10
11	Social Service Workers	1,974	2,145	34,476	16.07	11
12	Dietician					12
13	Food Service Supervisor	1,586	1,683	25,448	15.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,630	12,443	118,208	9.50	15
16	Dishwashers					16
17	Maintenance Workers	1,502	1,585	28,081	17.72	17
18	Housekeepers	9,873	10,567	111,838	10.58	18
19	Laundry	4,308	4,490	38,115	8.49	19
20	Administrator	2,185	2,302	78,715	34.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,207	40,007	18.13	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,228	113,910	$ 1,690,232 *	$ 14.84	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 11,002	1,3	35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		2,139	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,959	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		6,149	11,3	44
45	Social Service Consultant		2,322	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,571		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Brashear	Administrator	0	$ 78,715
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 78,715

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 251,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 251,200

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,206
Paycom Payroll, LLC	Payroll Processing	10,267
Personnel Planners, Inc.	Unemployment Consulting	1,685
Lamont, Hanley & Assoc, Inc.	Collection Fees	13
HK Payroll Services	WOTC	2,507
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 18,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,230
Unemployment Compensation Insurance	57,412
FICA Taxes	126,092
Employee Health Insurance	17,840
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,298
Employee Benefits	811
Other Employee Insurance	1,222
Related Party Allocation - Bridgemark	26,337
TOTAL (agree to Schedule V, line 22, col.8)	$ 308,242

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	2,100
Health Care Worker Background Check	6,444
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	4,733
Late Fees	4,183
Miscellaneous Licenses & Fees	
Advertising	63,939
Related Party Allocation - Bridgemark	861
Less: Public Relations Expense	( )
Non-allowable advertising	(63,939)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,311

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,671
Seminar Expense	3,501
Related Party Allocation - Bridgemark	5,054
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,226

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 $4,441**

(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? **3-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,447** 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. $ **166,560**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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 benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **425**

(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 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.

Helia Healthcare of Olney
Attachment to Schedule XII B
Equipment Rentals
12/31/2015

	Description	
16A	Nursing Equipment	3,629
16B	Related Party Allocation - Bridgemark Healthcare	627
		4,256