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.

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

I. IDPH License ID Number: 0046672

Facility Name: Helia Healthcare of Energy

Address: 210 E College Box519 (Number) Energy (City) 62933 (Zip Code)

County: Williamson

Telephone Number: (618) 942-7014 **Fax #** (618) 942-7196

HFS ID Number:

Date of Initial License for Current Owners: 02/01/04

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 01/01/16 to 12/31/16 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) Jason Mills
(Title) Director of Corporate Accounting and IT Systems

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East 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' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 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	84	Skilled (SNF)	84	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	7	Intermediate (ICF)	7	2,562	3
4	48	Intermediate/DD	48	17,568	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,874	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	10,879	2,607	10,969	24,455	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,879	2,607	10,969	24,455	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.07%

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 12/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 8,890

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	152,836	20,436	11,136	184,408		184,408		184,408			1
2	Food Purchase		152,453		152,453		152,453	(80)	152,373			2
3	Housekeeping	115,414	31,390	19,602	166,406		166,406		166,406			3
4	Laundry	15,951	18,870	39,667	74,488		74,488	(4,771)	69,717			4
5	Heat and Other Utilities			101,687	101,687		101,687	(8,269)	93,418			5
6	Maintenance	44,020	19,949	60,608	124,577		124,577	11,313	135,890			6
7	Other (specify):*											7
8	TOTAL General Services	328,221	243,098	232,700	804,019		804,019	(1,807)	802,212			8
	B. Health Care and Programs											
9	Medical Director			15,012	15,012		15,012		15,012			9
10	Nursing and Medical Records	1,647,721	91,578	27,413	1,766,712		1,766,712	12,340	1,779,052			10
10a	Therapy		741		741		741		741			10a
11	Activities	20,283	3,171	5,328	28,782		28,782	(1,124)	27,658			11
12	Social Services	32,756		2,790	35,546		35,546		35,546			12
13	CNA Training											13
14	Program Transportation			8,483	8,483		8,483		8,483			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,700,760	95,490	59,026	1,855,276		1,855,276	11,216	1,866,492			16
	C. General Administration											
17	Administrative	128,301		323,800	452,101		452,101	(299,912)	152,189			17
18	Directors Fees											18
19	Professional Services			20,695	20,695		20,695	3,767	24,462			19
20	Dues, Fees, Subscriptions & Promotions			77,698	77,698		77,698	(54,156)	23,542			20
21	Clerical & General Office Expenses	85,418	26,067	101,661	213,146		213,146	126,793	339,939			21
22	Employee Benefits & Payroll Taxes			376,500	376,500		376,500	30,597	407,097			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,471	4,471		4,471	4,580	9,051			24
25	Other Admin. Staff Transportation			8,388	8,388		8,388	14,835	23,223			25
26	Insurance-Prop.Liab.Malpractice			88,278	88,278		88,278	2,954	91,232			26
27	Other (specify):*											27
28	TOTAL General Administration	213,719	26,067	1,001,491	1,241,277		1,241,277	(170,542)	1,070,735			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,242,700	364,655	1,293,217	3,900,572		3,900,572	(161,133)	3,739,439			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.

Facility Name & ID Number Helia Healthcare of Energy #0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			24,526	24,526		24,526	4,562	29,088			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			136,417	136,417		136,417	(373)	136,044			32
33	Real Estate Taxes			72,073	72,073		72,073	448	72,521			33
34	Rent-Facility & Grounds			369,290	369,290		369,290	9,626	378,916			34
35	Rent-Equipment & Vehicles			51,397	51,397		51,397	(8,521)	42,876			35
36	Other (specify):*											36
37	**TOTAL Ownership**			653,703	653,703		653,703	5,742	659,445			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		455,573	1,080,380	1,535,953		1,535,953		1,535,953			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			170,398	170,398		170,398		170,398			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		455,573	1,250,778	1,706,351		1,706,351		1,706,351			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,242,700	820,228	3,197,698	6,260,626		6,260,626	(155,391)	6,105,235			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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(1,124)	11		4
5	Telephone, TV & Radio in Resident Rooms	(11,776)	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	(373)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(80)	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	(284)	20		17
18	Fines and Penalties	(488)	21		18
19	Entertainment	(3,208)	21		19
20	Contributions	(750)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(634)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(48,802)	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	(5,770)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,289)		$	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)	(82,102)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (82,102)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (155,391)		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

Helia Healthcare of Energy

ID# 0046672

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (4,689)	20	1
2	Eliminate Lobbying & PAC Dues	(2,918)	20	2
3	Offset Medical Records Income	(153)	10	3
4	Record IDPH fees paid in 2015	1,990	20	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**	(5,770)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(80)	0	0	0	0	0	0	0	0	0	0	(80)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(4,771)	0	0	0	0	0	0	0	0	(4,771)	4
5	Heat and Other Utilities	(11,776)	170	3,337	0	0	0	0	0	0	0	0	(8,269)	5
6	Maintenance	0	0	11,313	0	0	0	0	0	0	0	0	11,313	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,856)	170	9,879	0	0	0	0	0	0	0	0	(1,807)	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	(153)	12,493	0	0	0	0	0	0	0	0	0	12,340	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,124)	0	0	0	0	0	0	0	0	0	0	(1,124)	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**	(1,277)	12,493	0	0	0	0	0	0	0	0	0	11,216	16
	C. General Administration													
17	Administrative	0	(299,912)	0	0	0	0	0	0	0	0	0	(299,912)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(634)	3,846	555	0	0	0	0	0	0	0	0	3,767	19
20	Fees, Subscriptions & Promotions	(54,703)	547	0	0	0	0	0	0	0	0	0	(54,156)	20
21	Clerical & General Office Expenses	(4,446)	129,565	1,674	0	0	0	0	0	0	0	0	126,793	21
22	Employee Benefits & Payroll Taxes	0	19,759	10,838	0	0	0	0	0	0	0	0	30,597	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,580	0	0	0	0	0	0	0	0	0	4,580	24
25	Other Admin. Staff Transportation	0	5,879	8,956	0	0	0	0	0	0	0	0	14,835	25
26	Insurance-Prop.Liab.Malpractice	0	938	2,016	0	0	0	0	0	0	0	0	2,954	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(59,783)	(134,798)	24,039	0	0	0	0	0	0	0	0	(170,542)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,916)	(122,135)	33,918	0	0	0	0	0	0	0	0	(161,133)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy # 0046672 **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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,583	2,979	0	0	0	0	0	0	0	0	4,562	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(373)	0	0	0	0	0	0	0	0	0	0	(373)	32
33	Real Estate Taxes	0	18	430	0	0	0	0	0	0	0	0	448	33
34	Rent-Facility & Grounds	0	7,320	2,306	0	0	0	0	0	0	0	0	9,626	34
35	Rent-Equipment & Vehicles	0	0	(8,521)	0	0	0	0	0	0	0	0	(8,521)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(373)	8,921	(2,806)	0	0	0	0	0	0	0	0	5,742	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)**	(73,289)	(113,214)	31,112	0	0	0	0	0	0	0	0	(155,391)	45

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resouces
		Helia Healthcare of Olney	Olney, 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%	$ 170	$ 170	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	12,493	12,493	2
3	V	17	Management Fees	323,800	Bridgemark Healthcare, LLC	100.00%	23,888	(299,912)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	3,846	3,846	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	547	547	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	129,565	129,565	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	19,759	19,759	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,580	4,580	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,879	5,879	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	938	938	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,583	1,583	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	18	18	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,320	7,320	13
14	Total			$ 323,800			$ 210,586	$ * (113,214)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	35	Equipment Rental	$	Bridgemark Healthare, LLC	100.00%	$ 726	$ 726	15
16	V								16
17	V	21	Clearical & Office Supplies		Bridgemark Medical Supply	100.00%	13	13	17
18	V	30	Depreciation		Bridgemark Medical Supply	100.00%	1,343	1,343	18
19	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	516	516	19
20	V	35	Equipment Rental	9,247	Bridgemark Medical Supply	100.00%		(9,247)	20
21	V								21
22	V	4	Laundry	27,600	Helia Healthcare Services	100.00%	22,829	(4,771)	22
23	V	5	Utilities		Helia Healthcare Services	100.00%	3,337	3,337	23
24	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	14,313	11,313	24
25	V	19	Professional Services		Helia Healthcare Services	100.00%	555	555	25
26	V	21	Clerial & Office Supplies		Helia Healthcare Services	100.00%	1,661	1,661	26
27	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	10,838	10,838	27
28	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	8,956	8,956	28
29	V	26	Insurance		Helia Healthcare Services	100.00%	2,016	2,016	29
30	V	30	Depreciation		Helia Healthcare Services	100.00%	1,636	1,636	30
31	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	430	430	31
32	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	1,790	1,790	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 39,847			$ 70,959	$ * 31,112	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Florissant	Florissant, 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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	337,655	3.3	6.61	Distribution	$ 23,888	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	$ 23,888		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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	370,125	13	$ 2,569	$	24,455	$ 170	1
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	189,088	24,455	12,493	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		24,455	23,888	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		24,455	3,846	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280		24,455	547	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	24,455	104,113	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		24,455	25,452	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		24,455	19,759	8
9	24	Seminars	Resident Days	370,125	13	69,325		24,455	4,580	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		24,455	5,879	10
11	26	Insurance	Resident Days	370,125	13	14,200		24,455	938	11
12	30	Depreciation	Resident Days	370,125	13	23,966		24,455	1,583	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		24,455	18	13
14	34	Building Rent	Resident Days	370,125	13	102,424		24,455	6,767	14
15	34	Rental - Storage Unit	Resident Days	370,125	13	8,376		24,455	553	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		24,455	726	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,198,219	$ 1,764,830		$ 211,312	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	121,165	7	$ 168	$	9,247	$ 13	1
2	30	Depreciation	Revenue	121,165	7	17,596		9,247	1,343	2
3	34	Building Rent	Revenue	121,165	7	6,757		9,247	516	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					$ 24,521	$		$ 1,872	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: Helia Healthcare Services
Street Address: 308 Mcleansboro St
City / State / Zip Code: Benton, IL 62812
Phone Number: ((618) 435-3304
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	4	Laundry	Revenue	115,875	3	$ 86,447	$ 86,447	30,600	$ 22,829	1
2	5	Utilities	Revenue	115,875	3	12,637		30,600	3,337	2
3	6	Maintenance	Revenue	115,875	3	54,199	54,199	30,600	14,313	3
4	19	Professional Services	Revenue	115,875	3	2,102		30,600	555	4
5	21	Clerical & Office Supplies	Revenue	115,875	3	6,291		30,600	1,661	5
6	22	Payroll Taxes & Emp Benefits	Revenue	115,875	3	41,042		30,600	10,838	6
7	25	Other Admin Transportation	Revenue	115,875	3	33,916		30,600	8,956	7
8	26	Insurance	Revenue	115,875	3	7,635		30,600	2,016	8
9	30	Depreciation	Revenue	115,875	3	6,197		30,600	1,636	9
10	33	Real Estate Taxes	Revenue	115,875	3	1,627		30,600	430	10
11	34	Rent	Revenue	115,875	3	6,780		30,600	1,790	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					$ 258,873	$ 140,646		$ 68,361	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 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	136,417	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 136,417	9
	B. Non-Facility Related*											
10	Interest Income Offset										(373)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (373)	14
15	TOTALS (line 9+line14)						$	$			$ 136,044	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.)

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 72,940	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.)		$ 72,063	2
3. Under or (over) accrual (line 2 minus line 1).		$ (877)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,950	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.		$ 72,073	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	33,426	8
	2012	33,547	9
	2013	68,822	10
	2014	70,423	11
	2015	72,073	12

72,073 Line 7, Real Estate Tax Poriton of Lease Payments
18 Bridgemark Healthcare Allocation
430 Helia Healthcare Allocation
72,521 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

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.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-227-019	Long Term Care	$ 72,073.22	$ 72,073.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,073.22	$ 72,073.22

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 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.

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,850 B. General Construction Type: Exterior Brick Veneer Frame Mansonry Brick 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).

Home Adjacent to Facility - 206 East College (no assets or expenses are included for this building on the cost report)

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	Related Party Allocation - Helia Healthcare			$ 1,323	1
2					2
3	TOTALS			$ 1,323	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 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	Helia Healthcare Allocation		2006		$ 35,264	$	25	$ 621	$ 621	$ 4,491	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:			2004							9
10	"C" Wing Sings			2004	1,752						10
11	Handrail Molding			2004	1,000						11
12	Wallpaper			2004	1,740						12
13	Wallpaper			2004	1,062						13
14	Room Signs			2004	1,357						14
15	Paint Boarder			2004	2,253						15
16	Door Handles & Knobs			2004	729						16
17	Border for B Wing			2004	582						17
18	Wallpaper for C Wing			2004	1,107						18
19	Handrails, brackets			2004	1,093						19
20	Wire smoke detectors			2004	572						20
21	Door knobs B & C Wing			2004	766						21
22	2 Wall A/C Units			2005	1,035						22
23	Roof			2006	13,757						23
24	5 Wall A/C			2006	3,242						24
25	Smoke Detectors			2006	749						25
26	Fence			2006	573						26
27	Glass Door & Install			2007	1,210						27
28	Roof			2007	17,623						28
29	80 Gallon Water Heater			2007	2,829						29
30	Trailor for Resident Smokers			2008	1,295						30
31	Doors			2008	8,553						31
32	Wall Air Conditioner			2008	3,040						32
33	3 Wall A/C Units			2009	3,686						33
34	New Doors, Flooring, Wallcovering for entrance & Wing			2009	56,401						34
35	Roof Repair			2009	2,000						35
36	Call Cords			2009	1,255						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 Energy # 0046672 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 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	Exterior Brickwork Improvements	2010	$ 7,712	$		$	$	$	37
38	New Asphalt Parking Lot	2010	22,840						38
39	Heat/Water Pump System	2010	9,800						39
40	A/C Compressor Replacement	2010	1,999						40
41	Fire Protection System: Arch Wing	2010	7,971						41
42	15 Heat/Cool Wall Units	2010	7,753						42
43	10 Heat/Cool Wall Units	2010	5,530						43
44	Phone System	2010	17,144						44
45	S Hall (22rms) - New Doors, Window Bathrooms, Paint, Drywall	2011	56,140						45
46	W Hall (6 rms) - New Doors, Window Bathrooms, Paint, Drywall	2011	22,456						46
47	Nurses Station Improvements - new cabinets, counter, wiring, floo	2011	22,456						47
48	Dining Room - Flooring, drywall, lighting fixtures, paint	2011	33,684						48
49	Resident lounge area - electrical, lighting fixtures, drywall, paint	2011	22,456						49
50	Resident Kitchen Ara - New sinks, flooring, wiring, drywall, paint	2011	11,228						50
51	Therpay Room - Flooring, drywall, paint, lighting, window, labor	2011	22,456						51
52	2 Shower Rooms - Tile, shower heads, fixtures, paint, new plumbir	2011	33,684						52
53	Arch (Rehab) unit - Labor, doors, windows, drywall, paint flooring	2011	70,667						53
54	(cont.) fire alarms, plumbing, architect fees								54
55	Exterior Bickwork Improvements	2011	3,600						55
56	21 Wall A/C Units	2012	8,691						56
57	New Central Air unit on A wing	2012	2,700						57
58	Flooring	2012	1,780						58
59	Door Monitors & Keypads	2012	1,707						59
60	Heat/Cool Wall Units	2012	4,580						60
61	Bed Addition in ARCH unit	2013	34,951						61
62	Heating/Cool units	2013	3,919						62
63									63
64	4 A/C Units	2014	2,586	517	5	517		1,077	64
65	Tile, paint, vanities, toilets - A Wing	2014	3,971	397	10	397		1,158	65
66	Windows, tile door & vanities - B Wing	2014	3,584	358	10	358		955	66
67	A Wing Nurses Station	2014	1,450	145	10	145		350	67
68	Windows, laminate tops, paint, tile B Wing	2014	15,282	1,019	15	1,019		2,038	68
69	Kitchen, wiring install	2014	990	99	10	99		289	69
70	TOTAL (lines 4 thru 69)		$ 632,292	$ 2,535		$ 3,156	$ 621	$ 10,358	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 632,292	$ 2,535		$ 3,156	$ 621	$ 10,358	1
2	CTS Tech Phone Line Upgrade/Cabling Install	2014	5,113	511	10	511		1,469	2
3	Security I - Alarm System Install	2014	1,950	195	10	195		471	3
4	Windows	2014	925	93	10	93		209	4
5	A Wing Remodel Floor/Tile/Paint	2015	5,594	373	15	373		715	5
6	Kitchen Flooring & Laminate Countertop	2015	5,272	352	15	352		469	6
7	Vinyl Tile - A Wing	2016	9,121	760	10	760		760	7
8	Fire Alarm Replacement & 12 yr Suppression	2016	5,293	397	10	397		397	8
9	ARCH Remodel - labor, doors, windows, drywall, paint,								9
10	(cont.) flooring, fire alarms, plumbing, architect fees	2016	99,999	5,000	20	5,000		5,000	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19	Related Party Allocation - Bridgemark Healthcare LLC								19
20	New Office Build-Out	2011	8,974		20	475	475	2,591	20
21	Conference Room Chair Rail & Paint	2012	102		5	20	20	88	21
22									22
23									23
24	Relate Party Allocation - Helia Healthcare								24
25	Water & Sewer Pipe Installation	2006	502		20	25	25	261	25
26	Plumbing & Heating Installation	2006	601		20	30	30	313	26
27	A/C Unit - 4 Ton	2007	1,447		10	145	145	1,399	27
28	400 Gal. Water Storage Tank	2016	4,083		10	170	170	170	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 781,268	$ 10,216		$ 11,702	$ 1,486	$ 24,670	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 66,798	$ 10,134	$ 12,737	$ 2,603	3-15	$ 34,977	71
72	Current Year Purchases	32,678	1,691	2,164	473	3-15	2,164	72
73	Fully Depreciated Assets	21,602					21,602	73
74								74
75	TOTALS	$ 121,078	$ 11,825	$ 14,901	$ 3,076		$ 58,743	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		2014	$ 9,938	$ 2,485	$ 2,485	$	4	$ 6,832	76
77	Related Party Allocation - Bridgemark		2005	878				4	878	77
78	Related Party Allocation - Helia		2006	1,772				4	1,772	78
79										79
80	TOTALS			$ 12,588	$ 2,485	$ 2,485	$		$ 9,482	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)	$ 916,257	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,088	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,562	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 92,895	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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Champaign, Williamson, Franklin, L.L.C.
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. [X] 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:		139		$ 366,943			3
4	Additions							4
5	Related Party Allocations				9,626			5
6	Storage Rental				2,347			6
7	TOTAL		139		$ 378,916 **			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 12/20/13
    Ending 12/19/23

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$ 357,000
13.	/2018	$ 357,000
14.	/2019	$ 357,000

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: $ 42,876 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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,2	hrs	$		$	$ 107		$ 107	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				634		634	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				398,622		398,622	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					56,951		56,951	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				1,080,380			1,080,380	13
14	TOTAL			$		$ 1,080,380	$ 456,314		$ 1,536,694	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

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Energy **#** 0046672 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 2,293	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 123,400)	1,554,460		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,844		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	89,250		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,649,847	$	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	157,620		15
16	Equipment, at Historical Cost	83,072		16
17	Accumulated Depreciation (book methods)	(48,866)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	73,891		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 265,717	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,915,564	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,127,049	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,022		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,476		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,950		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessments	16,159		36
37	Due to Related Parties	491,860		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,857,516	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	180,106		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 180,106	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,037,622	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,122,058)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,915,564	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,144,512)	1
2	Restatements (describe):		2
3	**Prior Year Adjustment for Workers Comp Audit**	(104,230)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,248,742)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	126,684	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)**	$ 126,684	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)**	$ (1,122,058)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,361,008	1
2	Discounts and Allowances for all Levels	(69,067)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,291,941	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,157	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 95,157	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	268	13
14	Non-Patient Meals	1,124	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,136	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)**	$ 2,528	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	373	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 373	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	(2,842)	28
28a	Medical Record Copies	153	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,689)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,387,310	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	804,019	31
32	Health Care	1,855,276	32
33	General Administration	1,241,277	33
	B. Capital Expense		
34	Ownership	653,703	34
	C. Ancillary Expense		
35	Special Cost Centers	1,535,953	35
36	Provider Participation Fee	170,398	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,260,626	40
41	**Income before Income Taxes (line 30 minus line 40)****	126,684	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 126,684	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,274,420	44
45	Private Pay - Net Inpatient Revenue	368,928	45
46	Medicare - Net Inpatient Revenue	3,935,278	46
47	Other-(specify) Insurance	711,301	47
48	Other-(specify) Hospice	2,014	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,291,941	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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,999	2,102	$ 85,807	$ 40.82	1
2	Assistant Director of Nursing	1,531	1,565	46,655	29.81	2
3	Registered Nurses	13,497	14,046	383,428	27.30	3
4	Licensed Practical Nurses	15,876	16,800	368,265	21.92	4
5	CNAs & Orderlies	45,714	48,715	614,807	12.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,988	2,187	33,300	15.23	8
9	Activity Director					9
10	Activity Assistants	1,859	1,983	20,283	10.23	10
11	Social Service Workers	2,107	2,176	32,756	15.05	11
12	Dietician					12
13	Food Service Supervisor	1,868	2,022	34,619	17.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,251	11,647	118,217	10.15	15
16	Dishwashers					16
17	Maintenance Workers	1,994	2,156	44,020	20.42	17
18	Housekeepers	9,594	10,208	115,414	11.31	18
19	Laundry	1,657	1,657	15,951	9.63	19
20	Administrator	2,100	2,176	84,642	38.90	20
21	Assistant Administrator	1,898	2,142	43,659	20.38	21
22	Other Administrative	767	812	26,807	33.01	22
23	Office Manager	1,932	2,142	42,731	19.95	23
24	Clerical	714	820	15,880	19.37	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)	9,012	9,702	115,459	11.90	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,358	135,058	$ 2,242,700 *	$ 16.61	34

SEE ACCOUNTANTS' PREPARATION 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		$ 11,136	1,3	35
36	Medical Director		15,012	9,3	36
37	Medical Records Consultant		2,567	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,535	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		5,328	11,3	44
45	Social Service Consultant		2,790	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,368		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 Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yolanda Fisher	Administrator	0	$ 84,642
Judy Minor	Admin Asst.	0	43,659
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 128,301

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 323,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 323,800

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 3,775
Paycom Payroll, LLC	Payroll Processing	13,966
Personnel Planners, Inc.	Unemployment Consulting	1,532
Much Shelist	Legal - Bed increase	669
Ashman & Stein	Legal - IPG	119
Kramer & Frank	Collection fees - eliminated	153
Lamont, Hanley & Associates	Collection fees - eliminated	481
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 20,695

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 118,819
Unemployment Compensation Insurance	56,980
FICA Taxes	172,005
Employee Health Insurance	23,931
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,260
Employee Benefits	322
Other Employee Insurance	1,183
Related Party Allocation - Bridgemark	19,759
Related Party Allocation - Helia	10,838
TOTAL (agree to Schedule V, line 22, col.8)	$ 407,097

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	8,779
Health Care Worker Background Check	4,395
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	4,471
Late Fees	3,202
Miscellaneous Licenses & Fees	158
Advertising	48,802
Related Party Allocation - Bridgemark	547
Less: Public Relations Expense	( )
Non-allowable advertising	(48,802)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,732
Seminar Expense	1,739
Related Party Allocation - Bridgemark	4,580
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,051

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $4,470**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,323** 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? **Yes**
If YES, give effective date of lease. **12/20/13**

(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. $ **170,398**
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' PREPARATION 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. $ **1,124**

(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

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

	Description	
16A	Nursing Equipment	31,019
16B	Copier Lease	10,929
16C	Dietary Equipment	202
16D	Related Party Allocation - Bridgemark Healthcare	726
		42,876

Helia Healthcare of Energy
12/31/16

Account ID	Account Description	Date	Reference	Jrnl	Job Description	Trans Description	Debit Amt
90652	Travel: Mileage/Fuel	1/5/16	010516	PJ	Maintenance Specialist	Jewell Sims - mileage	213.95
90652	Travel: Mileage/Fuel	1/11/16	AK: 2016.01.11	CDJ	Post Acute Advisor	Amy Knope - Auto expense: mileage	434.13
90652	Travel: Mileage/Fuel	1/14/16	011416	PJ		Huck's - gas	6.67
90652	Travel: Mileage/Fuel	1/14/16	011416	PJ		Huck's - gas	6.67
90652	Travel: Mileage/Fuel	1/14/16	011416	PJ		Huck's - gas	6.66
90652	Travel: Mileage/Fuel	1/15/16	011516	PJ		Casey's - gas	13.34
90652	Travel: Mileage/Fuel	1/15/16	011516	PJ		Casey's - gas	13.34
90652	Travel: Mileage/Fuel	1/15/16	011516	PJ		Casey's - gas	13.32
90652	Travel: Mileage/Fuel	1/19/16	011916	PJ		Huck's - gas	20.00
90652	Travel: Mileage/Fuel	1/19/16	011916	PJ		Huck's - gas	20.00
90652	Travel: Mileage/Fuel	1/19/16	011916	PJ		Huck's - gas	20.00
90652	Travel: Mileage/Fuel	1/25/16	012516	PJ		Mach 1	46.00
90652	Travel: Mileage/Fuel	1/28/16	012816	PJ		Huck's	43.00
90652	Travel: Mileage/Fuel	2/1/16	020116	PJ		Casey's - gas	35.00
90652	Travel: Mileage/Fuel	2/1/16	AK: 2016-02-01	CDJ	Post Acute Advisor	Amy Knope - Auto Mileage	180.55
90652	Travel: Mileage/Fuel	2/10/16	021016	PJ		Huck's - gas	52.02
90652	Travel: Mileage/Fuel	2/12/16	021216	PJ	C.N.A.	Amanda McGee - gas	59.00
90652	Travel: Mileage/Fuel	2/17/16	021716	PJ		Huck's - gas	29.00
90652	Travel: Mileage/Fuel	2/17/16	021716	PJ	Director of Nursing	Sue Ann Coker - Mileage to/from STL for Matrix meeting	165.24
90652	Travel: Mileage/Fuel	2/22/16	022216	PJ	Maintenance Specialist	Jewell Sims - mileage	145.80
90652	Travel: Mileage/Fuel	2/22/16	YF: 2016-02-22	CDJ	Administrator	Yolanda Fisher - Gas for Van	52.00
90652	Travel: Mileage/Fuel	2/24/16	022416	PJ	Culinary Director	Stephanie Williams - mileage	116.10
90652	Travel: Mileage/Fuel	2/26/16	022616	PJ		Huck's - gas	51.01
90652	Travel: Mileage/Fuel	2/28/16	022816	PJ	Director of Social Services	Kelly Davis - Mileage/meals for a work related training	149.29
90652	Travel: Mileage/Fuel	3/1/16	030116	PJ	Director of Guest Relations	Laura Coloni - mileage	108.96
90652	Travel: Mileage/Fuel	3/4/16	030416	PJ		Casey's	44.55
90652	Travel: Mileage/Fuel	3/4/16	030416	PJ		Huck's	58.00
90652	Travel: Mileage/Fuel	3/17/16	031716	PJ	Director of Nursing	Sue Ann Coker - mileage	123.12
90652	Travel: Mileage/Fuel	3/23/16	032316	PJ	Maintenance Specialist	Jewell Sims - mileage	189.00
90652	Travel: Mileage/Fuel	3/29/16	032916	PJ		Huck's - gas	57.60
90652	Travel: Mileage/Fuel	3/29/16	032916	PJ	C.N.A.	Amanda McGee - gas	52.00
90652	Travel: Mileage/Fuel	4/4/16	YF: 2016-04-04	CDJ	Administrator	Yolanda Fisher - Gas	52.50
90652	Travel: Mileage/Fuel	5/1/16	040116	PJ		Huck's - gas	56.00
90652	Travel: Mileage/Fuel	5/1/16	040616	PJ	Maintenance Specialist	Jewell Sims	174.96
90652	Travel: Mileage/Fuel	5/1/16	041416	PJ		Huck's - gas	53.74
90652	Travel: Mileage/Fuel	5/1/16	041216	PJ		Huck's	50.01
90652	Travel: Mileage/Fuel	5/1/16	041916	PJ	Maintenance Specialist	Jewell Sims - mileage	132.84
90652	Travel: Mileage/Fuel	5/1/16	042516	PJ		Huck's - gas	54.18
90652	Travel: Mileage/Fuel	5/1/16	042516	PJ	Maintenance Specialist	Jewell Sims - mileage	186.84
90652	Travel: Mileage/Fuel	5/6/16	050616	PJ		Huck's - gas	51.58
90652	Travel: Mileage/Fuel	5/9/16	AK: 2016-05-09	CDJ	Post Acute Advisor	Amy Knope - Auto Mileage	194.40
90652	Travel: Mileage/Fuel	5/19/16	051916	PJ		Huck's - gas	51.05
90652	Travel: Mileage/Fuel	5/31/16	053116	PJ		Huck's	51.61
90652	Travel: Mileage/Fuel	6/3/16	19163	CDJ		Huck's - Fuel for facility vehicle	57.34
90652	Travel: Mileage/Fuel	6/6/16	AK: 2016-06-06	CDJ	Post Acute Advisor	Amy Knope - Auto expense: mileage	233.28
90652	Travel: Mileage/Fuel	6/8/16	19170	CDJ		Huck's - Fuel for facility vehicle	63.88
90652	Travel: Mileage/Fuel	6/23/16	19195	CDJ		Huck's - fuel for facility vehicle	44.93
90652	Travel: Mileage/Fuel	6/29/16	19198	CDJ		Huck's - Fuel for facility vehicle	49.80
90652	Travel: Mileage/Fuel	7/1/16	070116	PJ		Huck's	49.80
90652	Travel: Mileage/Fuel	7/8/16	19210	CDJ		Huck's - Travel: Mileage/Fuel	57.41
90652	Travel: Mileage/Fuel	7/14/16	19219	CDJ		Huck's - fuel for facility vehicle	46.93
90652	Travel: Mileage/Fuel	7/18/16	19221	CDJ		Huck's - fuel for facility vehicle	53.35
90652	Travel: Mileage/Fuel	7/21/16	19224	CDJ	Assistant Administrator	Judy Minor - reimb. for mileage	275.40
90652	Travel: Mileage/Fuel	7/28/16	072816	PJ	Assistant Administrator	Judy Minor	78.00
90652	Travel: Mileage/Fuel	8/1/16	AK: 2016-07-18	CDJ	Post Acute Advisor	Amy Knope - Auto Mileage	113.40
90652	Travel: Mileage/Fuel	8/2/16	19235	CDJ		Huck's - facility vehicle fuel	52.12
90652	Travel: Mileage/Fuel	8/8/16	081616	PJ		Lakezone Convenience - gas for van	58.75
90652	Travel: Mileage/Fuel	8/15/16	19250	CDJ		Huck's - fuel for facility vehicle	52.79
90652	Travel: Mileage/Fuel	8/22/16	19264	CDJ		Huck's - fuel for transport van	54.68
90652	Travel: Mileage/Fuel	9/1/16	090116	PJ		Huck's	49.23
90652	Travel: Mileage/Fuel	9/1/16	072816	PJ		Huck's	3.69
90652	Travel: Mileage/Fuel	9/6/16	19280	CDJ		Huck's - Travel: Mileage/Fuel	48.48
90652	Travel: Mileage/Fuel	9/8/16	19282	CDJ	Assistant Administrator	Judy Minor - Travel: Mileage/Fuel	158.98
90652	Travel: Mileage/Fuel	9/12/16	19287	CDJ		Huck's - Travel: Mileage/Fuel	55.57
90652	Travel: Mileage/Fuel	9/23/16	19304	CDJ		Huck's - Travel: Mileage/Fuel	52.56
90652	Travel: Mileage/Fuel	9/27/16	19309	CDJ		Huck's - Travel: Mileage/Fuel	42.04
90652	Travel: Mileage/Fuel	9/30/16	19313	CDJ		Huck's - Travel: Mileage/Fuel	47.63
90652	Travel: Mileage/Fuel	10/4/16	19317	CDJ		Huck's - Travel: Mileage/Fuel	54.48
90652	Travel: Mileage/Fuel	10/14/16	19336	CDJ		Huck's - Travel: Mileage/Fuel	46.05
90652	Travel: Mileage/Fuel	10/20/16	19341	CDJ		Huck's - Travel: Mileage/Fuel	43.64
90652	Travel: Mileage/Fuel	10/31/16	19349	CDJ		Casey's - Travel: Mileage/Fuel	76.76
90652	Travel: Mileage/Fuel	10/31/16	103116	PJ		Huck's	45.97
90652	Travel: Mileage/Fuel	11/8/16	19365	CDJ		Huck's - Travel: Mileage/Fuel	41.51
90652	Travel: Mileage/Fuel	11/10/16	111016	PJ		Huck's - gas	21.70
90652	Travel: Mileage/Fuel	11/21/16	19376	CDJ		Huck's - Travel: Mileage/Fuel	40.79
90652	Travel: Mileage/Fuel	12/5/16	19388	CDJ		Huck's - Travel: Mileage/Fuel	47.76
90652	Travel: Mileage/Fuel	12/16/16	19434	CDJ		Huck's - Travel: Mileage/Fuel	47.99
90652	Travel: Mileage/Fuel	12/31/16	M/E: Clean-Up	GENJ	ARCH MDS Coordinator	9/2/16_19279_CDJ_Karen Bowles - emp. reimb. for mileage_	210.93
90651	Travel: Vehicle Repairs/Tires						2,275.51
							8,388.16