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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0049775

Facility Name: Helia Healthcare of Benton

Address: 1310 Mark Franklin Louis Street (Number) Benton (City) 62812 (Zip Code)

County: Franklin

Telephone Number: (618) 932-3236 **Fax #** (618) 937-1171

HFS ID Number:

Date of Initial License for Current Owners: 8/15/08

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 01/01/17 to 12/31/17 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) Chief Financial Officer

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 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' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	83	Skilled (SNF)	83	30,295	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	83	TOTALS	83	30,295	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	12,903	6,351	5,677	24,931	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,903	6,351	5,677	24,931	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.29%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 08/15/08

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 5,070

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: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	97,830	16,528	116,955	231,313		231,313	(4,000)	227,313			1
2	Food Purchase		215,684		215,684		215,684	(83)	215,601			2
3	Housekeeping	141,396	44,620	3,691	189,707		189,707		189,707			3
4	Laundry	19,445	11,469	74,536	105,450		105,450	(14,828)	90,622			4
5	Heat and Other Utilities			92,283	92,283		92,283	8,722	101,005			5
6	Maintenance	2,358	38,384	40,814	81,556		81,556	80,652	162,208			6
7	Other (specify):*											7
8	TOTAL General Services	261,029	326,685	328,279	915,993		915,993	70,463	986,456			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,260,073	105,743	18,301	1,384,117		1,384,117	22,587	1,406,704			10
10a	Therapy		230		230		230	4,310	4,540			10a
11	Activities	35,856	21,663	3,921	61,440		61,440	(835)	60,605			11
12	Social Services	38,346	28	2,023	40,397		40,397		40,397			12
13	CNA Training											13
14	Program Transportation					1,422	1,422		1,422			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,334,275	127,664	42,245	1,504,184	1,422	1,505,606	26,062	1,531,668			16
	C. General Administration											
17	Administrative	83,407		267,000	350,407		350,407	(212,331)	138,076			17
18	Directors Fees											18
19	Professional Services			18,498	18,498		18,498	17,374	35,872			19
20	Dues, Fees, Subscriptions & Promotions			80,125	80,125		80,125	(48,627)	31,498			20
21	Clerical & General Office Expenses	94,741	23,677	119,809	238,227		238,227	132,015	370,242			21
22	Employee Benefits & Payroll Taxes			246,637	246,637		246,637	40,569	287,206			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,462	1,462		1,462	6,281	7,743			24
25	Other Admin. Staff Transportation			5,815	5,815	(1,422)	4,393	21,879	26,272			25
26	Insurance-Prop.Liab.Malpractice			85,107	85,107		85,107	2,785	87,892			26
27	Other (specify):*											27
28	TOTAL General Administration	178,148	23,677	824,453	1,026,278	(1,422)	1,024,856	(40,055)	984,801			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,773,452	478,026	1,194,977	3,446,455		3,446,455	56,470	3,502,925			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 Benton #0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			22,079	22,079		22,079	15,937	38,016			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,333	51,333		51,333	61	51,394			32
33	Real Estate Taxes			40,031	40,031		40,031	(19,128)	20,903			33
34	Rent-Facility & Grounds			302,950	302,950		302,950	(289,210)	13,740			34
35	Rent-Equipment & Vehicles			55,135	55,135		55,135	(1,078)	54,057			35
36	Other (specify):*											36
37	**TOTAL Ownership**			471,528	471,528		471,528	(293,418)	178,110			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		223,145	613,412	836,557		836,557	(5,768)	830,789			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,979	163,979		163,979		163,979			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		223,145	777,391	1,000,536		1,000,536	(5,768)	994,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,773,452	701,171	2,443,896	4,918,519		4,918,519	(242,716)	4,675,803			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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(835)	11		4
5	Telephone, TV & Radio in Resident Rooms	(5,837)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(83)	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	(650)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,206)	21		19
20	Contributions	(783)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(40,784)	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	(7,951)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,129)		$	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)	(181,587)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (181,587)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (242,716)		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 Benton

ID# 0049775

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (4,285)	20	1
2	Eliminate Lobbying & PAC Dues	(1,676)	20	2
3	Elminate 2018 IDPH Fees paid in 2017	(1,990)	20	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**	(7,951)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(4,000)	0	0	0	0	0	0	0	0	(4,000)	1
2	Food Purchase	(83)	0	0	0	0	0	0	0	0	0	0	(83)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(14,828)	0	0	0	0	0	0	0	0	(14,828)	4
5	Heat and Other Utilities	(5,837)	217	14,342	0	0	0	0	0	0	0	0	8,722	5
6	Maintenance	0	0	80,652	0	0	0	0	0	0	0	0	80,652	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,920)	217	76,166	0	0	0	0	0	0	0	0	70,463	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	22,587	0	0	0	0	0	0	0	0	0	22,587	10
10a	Therapy	0	0	0	4,310	0	0	0	0	0	0	0	4,310	10a
11	Activities	(835)	0	0	0	0	0	0	0	0	0	0	(835)	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**	(835)	22,587	0	4,310	0	0	0	0	0	0	0	26,062	16
	C. General Administration													
17	Administrative	0	(213,439)	0	1,108	0	0	0	0	0	0	0	(212,331)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,276	2,098	0	0	0	0	0	0	0	0	17,374	19
20	Fees, Subscriptions & Promotions	(49,385)	758	0	0	0	0	0	0	0	0	0	(48,627)	20
21	Clerical & General Office Expenses	(4,989)	133,776	3,147	81	0	0	0	0	0	0	0	132,015	21
22	Employee Benefits & Payroll Taxes	0	19,311	20,487	771	0	0	0	0	0	0	0	40,569	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,237	0	44	0	0	0	0	0	0	0	6,281	24
25	Other Admin. Staff Transportation	0	6,400	15,354	125	0	0	0	0	0	0	0	21,879	25
26	Insurance-Prop.Liab.Malpractice	0	1,842	934	9	0	0	0	0	0	0	0	2,785	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(54,374)	(29,839)	42,020	2,138	0	0	0	0	0	0	0	(40,055)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,129)	(7,035)	118,186	6,448	0	0	0	0	0	0	0	56,470	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Helia Healthcare of Benton** **#** **0049775** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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**	**1,439**	**14,498**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15,937**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**61**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**61**	**32**
33	Real Estate Taxes	**0**	**19**	**(19,147)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(19,128)**	**33**
34	Rent-Facility & Grounds	**0**	**6,813**	**(296,023)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(289,210)**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**(1,078)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,078)**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**8,271**	**(301,750)**	**61**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(293,418)**	**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**	**(5,768)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(5,768)**	**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**	**(5,768)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(5,768)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(61,129)**	**1,236**	**(183,564)**	**741**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(242,716)**	**45**

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical S	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 Clin	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%	$ 217	$ 217	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	22,587	22,587	2
3	V	17	Management Fees	267,000	Bridgemark Healthcare, LLC	100.00%	53,561	(213,439)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	15,276	15,276	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	758	758	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	133,776	133,776	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	19,311	19,311	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	6,237	6,237	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	6,400	6,400	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,842	1,842	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,439	1,439	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	19	19	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	6,813	6,813	13
14	Total			$ 267,000			$ 268,236	$ * 1,236	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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Healthcare, LLC	100.00%	$ 640	$ 640	15
16	V								16
17	V	35	Equipment Rental	2,097	Bridgemark Medical Supply	100.00%		(2,097)	17
18	V	30	Depreciation		Bridgemark Medical Supply	100.00%	476	476	18
19	V	34	Building Rent		Bridgemark Medical Supply	100.00%	56	56	19
20	V								20
21	V	1	Dietary	4,000	Helia Healthcare Services	100.00%		(4,000)	21
22	V	4	Laundry	74,400	Helia Healthcare Services	100.00%	59,572	(14,828)	22
23	V	5	Utilities		Helia Healthcare Services	100.00%	14,342	14,342	23
24	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	83,652	80,652	24
25	V	19	Professional Services		Helia Healthcare Services	100.00%	2,098	2,098	25
26	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	3,147	3,147	26
27	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	20,487	20,487	27
28	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	15,354	15,354	28
29	V	26	Insurance		Helia Healthcare Services	100.00%	934	934	29
30	V	30	Depreciation		Helia Healthcare Services	100.00%	5,781	5,781	30
31	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,853	1,853	31
32	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	3,101	3,101	32
33	V	35	Rent - Vehicle		Helia Healthcare Services	100.00%	379	379	33
34	V								34
35	V	30	Depreciation		BM Properties I - Benton	100.00%	8,241	8,241	35
36	V	33	Real Estate Taxes	21,000	BM Properties I - Benton	100.00%		(21,000)	36
37	V	34	Rent - Facility & Grounds	302,950	BM Properties I - Benton	100.00%	3,770	(299,180)	37
38	V								38
39	Total			$ 407,447			$ 223,883	$ * (183,564)	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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10a	Therapy	$	NW Rehab, LLC	100.00%	$ 4,310	$ 4,310	15
16	V	17	Admin Salaries		NW Rehab, LLC	100.00%	1,108	1,108	16
17	V	21	Clerical & General Office		NW Rehab, LLC	100.00%	81	81	17
18	V	22	Employee Benefits		NW Rehab, LLC	100.00%	771	771	18
19	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	44	44	19
20	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	125	125	20
21	V	26	Insurance - Prop, Liab, Malprac		NW Rehab, LLC	100.00%	9	9	21
22	V	32	Interest		NW Rehab, LLC	100.00%	61	61	22
23	V	39	Ancillary Service Centers	5,768	NW Rehab, LLC	100.00%		(5,768)	23
24	V								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			$ 5,768			$ 6,509	$ * 741	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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	723,227	3.45	6.90	Distribution	$ 53,561	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	$ 53,561		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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	361,568	13	$ 3,142	$	24,931	$ 217	1
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	24,931	22,587	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788		24,931	53,561	3
4	19	Professional Fees	Resident Days	361,568	13	221,539		24,931	15,276	4
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991		24,931	758	5
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	24,931	107,644	6
7	21	Clercial & Office Supplies	Resident Days	361,568	13	378,981		24,931	26,132	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058		24,931	19,311	8
9	24	Travel & Seminar	Resident Days	361,568	13	90,455		24,931	6,237	9
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816		24,931	6,400	10
11	26	Insurance	Resident Days	361,568	13	26,711		24,931	1,842	11
12	30	Depreciation	Resident Days	361,568	13	20,874		24,931	1,439	12
13	33	Real Estate Taxes	Resident Days	361,568	13	269		24,931	19	13
14	34	Building Rent	Resident Days	361,568	13	95,732		24,931	6,601	14
15	34	Rental - Storage Unit	Resident Days	361,568	13	3,073		24,931	212	15
16	35	Equipment Rental	Resident Days	361,568	13	9,286		24,931	640	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,899,417	$ 1,888,702		$ 268,876	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	30	Depreciation	Revenue	70,485	7	$ 17,596	$	1,908	$ 476	1
2	34	Rent	Revenue	70,485	7	2,079		1,908	56	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	TOTALS					$ 19,675	$		$ 532	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Street
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	178,000	3	$ 130,267	$ 130,267	81,400	$ 59,572	1
2	5	Utilities	Revenue	178,000	3	31,363		81,400	14,342	2
3	6	Maintenance	Revenue	178,000	3	182,925	182,925	81,400	83,652	3
4	19	Professional Services	Revenue	178,000	3	4,588		81,400	2,098	4
5	21	Clerical & Office Supplies	Revenue	178,000	3	6,882		81,400	3,147	5
6	22	Payroll Taxes & Emp Benefits	Revenue	178,000	3	44,799		81,400	20,487	6
7	25	Other Admin Transportation	Revenue	178,000	3	33,574		81,400	15,354	7
8	26	Insurance	Revenue	178,000	3	2,042		81,400	934	8
9	30	Depreciation	Revenue	178,000	3	12,642		81,400	5,781	9
10	33	Real Estate Taxes	Revenue	178,000	3	4,052		81,400	1,853	10
11	34	Rent - Facility	Revenue	178,000	3	6,780		81,400	3,101	11
12	35	Rent - Vehicle	Revenue	178,000	3	829		81,400	379	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					$ 460,743	$ 313,192		$ 210,700	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 NW Rehab, LLC
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	10a	Therapy	Revenue	2,581,783	19	$ 1,610,941	$ 1,610,941	6,907	$ 4,310	1
2	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	6,907	1,108	2
3	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456		6,907	81	3
4	22	Employee Benefits	Revenue	2,581,783	19	288,251		6,907	771	4
5	24	Travel & Seminar	Revenue	2,581,783	19	16,377		6,907	44	5
6	25	Other Admin Transp	Revenue	2,581,783	19	46,860		6,907	125	6
7	26	Insurance - Prop, Liab, Malprac	Revenue	2,581,783	19	3,500		6,907	9	7
8	32	Interest	Revenue	2,581,783	19	22,721		6,907	61	8
9	10	Nursing & Med	Revenue	2,581,783	19	73		6,907		9
10	20	Dues & Subscriptions	Revenue	2,581,783	19	136		6,907		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					$ 2,433,379	$ 2,025,005		$ 6,509	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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, LLC		X	Line of Credit		10/22/09				Variable	51,333	6
7												7
8	Related Party Allocation										61	8
9	TOTAL Facility Related						$	$			$ 51,394	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 51,394	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 Benton # 0049775 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 3,877	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.)		$ 19,879	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,002	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,423	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.		$ 39,425	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013	18,765	9
2014	19,031	10
2015	19,092	11
2016	19,879	12

39,425 Line 7
(19,128) Related Party Adjustments
606 Prior Year Adjustments
20,903 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-07-455-802	Sec 07 TWP 06 RNG 03 E 1.68	$ 19,878.92	$ 19,878.92
2.		AC SW COR 1/4 SW 1/4	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,878.92	$ 19,878.92

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,067 B. General Construction Type: Exterior Brick Masonry Frame Metal Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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			$ 2,291	1
2					2
3	TOTALS			$ 2,291	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 61,066	$	25	$ 3,053	$ 3,053	$ 10,830	4
5	83		2008		134,098		30	4,470	4,470	42,092	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		726	9
10	Exterior Sign			2009	5,265	527	10	527		4,651	10
11	Wallcovering for hallways & entrancway, door, shower remodel			2009	11,252	750	15	750		6,251	11
12	Carpet			2009	1,170		5			1,170	12
13	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		1,406	13
14	New Pipes, Install Eye Wash			2010	2,215	89	25	89		672	14
15	AC, Fans, Dehumidifier			2010	1,609	161	10	161		1,207	15
16	Outside Singe Door & Frame			2010	4,168	278	15	278		2,015	16
17	Shower Room - Tile, shower heads, electrical work, fixutres, paint			2011	3,860	257	15	257		1,692	17
18	Dinette/Common Area remodel - doors, windows, countertops, cabinetry										18
19	(cont.) Flooring, electrical, plywood, paint			2011	13,693	913	15	913		6,011	19
20	Back-Up Generator			2011	12,864	643	20	643		4,074	20
21	Sprinker System			2012	97,800	3,912	25	3,912		23,472	21
22	Fire Doors			2012	9,942	663	15	663		3,867	22
23	Oxygen Shed			2012	1,941	194	10	194		1,051	23
24	AC Equipment North Hallway			2014	1,896	190	10	190		664	24
25	Painting 1 Room, 1/2 North Hall			2014	250	50	5	50		158	25
26	Therapy Remodel - flooring, painting, & lighing			2015	4,045	270	15	270		719	26
27	Vinyl Sliding Door & Installation			2015	5,325	355	15	355		858	27
28	Flooring in North Hall rooms and hallway			2015	7,282	485	15	485		1,133	28
29	Lighting, Drywall, Paint and Flooring in Back Hallway			2017	4,690	156	15	156		156	29
30	New Countertop and Paint for Nurse Station in South Hall			2017	2,922	49	15	49		49	30
31	Lights, Flooring, Paint, Door Handles, and new Cabinets for										31
32	Therapy Room			2017	16,563	460	15	460		460	32
33	New Pipes and Plumbing for North Hall Shower			2017	2,077	58	15	58		58	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Related Party Allocation - Bridgemark Healthcare LLC		$	$		$	$	$	37
38	New Office Build Out	2011	9,365		20	496	496	3,200	38
39	Conference Room Chair Rail & Paint	2012	106		5	14	14	106	39
40									40
41	Related Party Allocation - Helia Healthcare								41
42	Water & Sewer Pipe Installation	2006	869		20	43	43	496	42
43	Plumbing & Heating Installation	2006	1,040		20	52	52	594	43
44	A/C Unit - 4 Ton	2007	2,506		10	84	84	2,506	44
45	400 Gal. Water Storage Tank	2016	7,071		10	707	707	1,002	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									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 430,727	$ 10,711		$ 19,630	$ 8,919	$ 123,346	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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 168,025	$ 11,146	$ 17,784	$ 6,638	3-15	$ 93,441	71
72	Current Year Purchases	8,964	222	602	380	3-15	602	72
73	Fully Depreciated Assets	42,445					42,445	73
74								74
75	TOTALS	$ 219,434	$ 11,368	$ 18,386	$ 7,018		$ 136,488	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2011	$ 28,821	$	$	$	4	$ 28,821	76
77	Related Party Allocation - Bridgemark		2005	916				4	916	77
78	Related Party Allocation - Helia Healthcare		2006	3,069				4	3,069	78
79										79
80	TOTALS			$ 32,806	$	$	$		$ 32,806	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)	$ 685,258	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,079	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,016	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,937	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 292,640	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.

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Related Party Allocation				13,740			6
7	TOTAL				$ 13,740 **			7

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: *

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: $ 54,057 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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

Facility Name & ID Number Helia Healthcare of Benton

STATE OF ILLINOIS
0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				230		230	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				191,377		191,377	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					31,768		31,768	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				613,412			613,412	13
14	TOTAL			$		$ 613,412	$ 223,375		$ 836,787	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 Benton **#** 0049775 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 4,358	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 67,381)	1,023,477		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,664		7
8	Accounts Receivable (owners or related parties)	5,792,537		8
9	Other(specify): Deposits	1,426		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,823,462	$	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	214,607		15
16	Equipment, at Historical Cost	158,008		16
17	Accumulated Depreciation (book methods)	(158,676)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	23,423		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 237,362	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,060,824	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,599,568	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,958		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,193		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,423		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	20,614		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,707,756	$	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	Note Payable - Owner	123,729		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 123,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,831,485	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,229,339	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,060,824	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Benton **#** 0049775 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,823,884	1
2	Restatements (describe):		2
3	**Prior Year Adjustment made after cost report was submitted**	(14,887)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,808,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	420,342	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)**	$ 420,342	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)**	$ 3,229,339	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 5,243,512	1
2	Discounts and Allowances for all Levels	(72,137)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,171,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,686	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 122,686	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	835	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 835	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	43,965	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,965	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,338,861	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	915,993	31
32	Health Care	1,504,184	32
33	General Administration	1,026,278	33
	B. Capital Expense		
34	Ownership	471,528	34
	C. Ancillary Expense		
35	Special Cost Centers	836,557	35
36	Provider Participation Fee	163,979	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,918,519	40
41	**Income before Income Taxes (line 30 minus line 40)****	420,342	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 420,342	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,632,758	44
45	Private Pay - Net Inpatient Revenue	875,639	45
46	Medicare - Net Inpatient Revenue	2,469,748	46
47	Other-(specify) Insurance	181,574	47
48	Other-(specify) Hospice	11,656	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,171,375	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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,827	2,037	$ 69,175	$ 33.96	1
2	Assistant Director of Nursing	1,317	2,210	27,037	12.23	2
3	Registered Nurses	10,461	10,932	291,998	26.71	3
4	Licensed Practical Nurses	13,032	13,877	309,248	22.28	4
5	CNAs & Orderlies	47,707	50,359	557,587	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,769	2,960	35,856	12.11	10
11	Social Service Workers	2,109	2,242	38,346	17.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,982	8,596	97,830	11.38	15
16	Dishwashers					16
17	Maintenance Workers	230	230	2,358	10.25	17
18	Housekeepers	10,953	12,044	141,396	11.74	18
19	Laundry	2,065	2,239	19,445	8.68	19
20	Administrator	1,868	2,049	83,407	40.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,065	2,312	52,657	22.78	23
24	Clerical	1,902	2,074	42,084	20.29	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	197	580	5,028	8.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,484	114,741	$ 1,773,452 *	$ 15.46	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		$		35
36	Medical Director		18,000	9,3	36
37	Medical Records Consultant		1,375	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,095	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,921	11,3	44
45	Social Service Consultant		2,023	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,414		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 Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Loretta Ellis	Administrator	0	$ 83,407
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,407

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Mangement Fee	$ 267,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 267,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting	$ 1,093
Personnel Planners, Inc.	Unemployment Consulting	1,815
Craig and Craig	Legal Fees	3,845
Ashman & Stein	Legal Fees	118
Paycom Payroll, LLC	Payroll Processing	11,627
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 18,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,763
Unemployment Compensation Insurance	37,890
FICA Taxes	135,203
Employee Health Insurance	18,682
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,147
Employee Benefits	7,925
Other Employee Insurance	27
Related Party Allocation - Bridgemark	19,311
Related Party Allocation - Helia Healthcare	20,487
Related Party Allocation - NW Rehab	771
TOTAL (agree to Schedule V, line 22, col.8)	$ 287,206

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	12,284
Health Care Worker Background Check	3,810
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	9,564
Late Fees	2,740
Miscellaneous Licenses & Fees	352
Advertising	40,784
Related Party Allocation - Bridgemark	758
Less: Public Relations Expense	( )
Non-allowable advertising	(40,784)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,498

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	480
Seminar Expense	982
Related Party Allocation - Bridgemark	6,237
Related Party Allocation - NW Rehab	44
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,743

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,092**

(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. $ **15,380** 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. $ **163,979**
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. $ **835**

(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 Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2017

	Description	
16A	Nursing Equipment	33,346
16B	Copier Lease	5,234
16C	Dietary Equipment	1,449
16D	Related Party Allocation - Bridgemark Healthcare	640
16E	Related Party Allocation - Helia Healthcare	379
16F	Storage	2,364
16G	Computers & Software	10,645
		54,057