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: 0048181

Facility Name: Helia Healthcare of Champaign

Address: 1915 South Mattis Street (Number) Champaign (City) 61821 (Zip Code)

County: Champaign

Telephone Number: (217) 352-0516 **Fax #** (217) 352-0976

HFS ID Number:

Date of Initial License for Current Owners: 05/01/06

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 Champaign # 0048181 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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,952	3,759	5,847	21,558	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,952	3,759	5,847	21,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.05%

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 05/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 2,735

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 Champaign # 0048181 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	161,910	25,245	8,610	195,765		195,765		195,765			1
2	Food Purchase		134,117		134,117		134,117	(116)	134,001			2
3	Housekeeping	83,758	19,350	4,535	107,643		107,643		107,643			3
4	Laundry	35,423	9,694	2,022	47,139		47,139		47,139			4
5	Heat and Other Utilities			118,363	118,363		118,363	(24,549)	93,814			5
6	Maintenance	41,902	22,774	61,841	126,517		126,517		126,517			6
7	Other (specify):*											7
8	TOTAL General Services	322,993	211,180	195,371	729,544		729,544	(24,665)	704,879			8
	B. Health Care and Programs											
9	Medical Director			20,000	20,000		20,000		20,000			9
10	Nursing and Medical Records	1,339,600	97,721	28,055	1,465,376		1,465,376	19,332	1,484,708			10
10a	Therapy			124	124		124	5,630	5,754			10a
11	Activities	33,073	7,444	4,161	44,678		44,678		44,678			11
12	Social Services	48,126	145	2,857	51,128		51,128		51,128			12
13	CNA Training											13
14	Program Transportation			4,405	4,405	270	4,675		4,675			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,420,799	105,310	59,602	1,585,711	270	1,585,981	24,962	1,610,943			16
	C. General Administration											
17	Administrative	148,226		231,000	379,226		379,226	(183,238)	195,988			17
18	Directors Fees											18
19	Professional Services			15,116	15,116		15,116	13,009	28,125			19
20	Dues, Fees, Subscriptions & Promotions			128,740	128,740		128,740	(55,819)	72,921			20
21	Clerical & General Office Expenses	62,165	15,332	147,339	224,836		224,836	110,215	335,051			21
22	Employee Benefits & Payroll Taxes			261,190	261,190		261,190	17,705	278,895			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,974	12,974	(8,724)	4,250	5,450	9,700			24
25	Other Admin. Staff Transportation			5,474	5,474	(270)	5,204	5,698	10,902			25
26	Insurance-Prop.Liab.Malpractice			114,177	114,177		114,177	1,605	115,782			26
27	Other (specify):*											27
28	TOTAL General Administration	210,391	15,332	916,010	1,141,733	(8,994)	1,132,739	(85,375)	1,047,364			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,954,183	331,822	1,170,983	3,456,988	(8,724)	3,448,264	(85,078)	3,363,186			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 Champaign #0048181 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			57,126	57,126		57,126	1,245	58,371			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,829	51,829		51,829	(229)	51,600			32
33	Real Estate Taxes			36,316	36,316		36,316	16	36,332			33
34	Rent-Facility & Grounds			338,797	338,797		338,797	5,891	344,688			34
35	Rent-Equipment & Vehicles			28,638	28,638	8,724	37,362	554	37,916			35
36	Other (specify):*											36
37	**TOTAL Ownership**			512,706	512,706	8,724	521,430	7,477	528,907			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		239,669	645,717	885,386		885,386	(7,688)	877,698			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,314	174,314		174,314		174,314			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		239,669	820,031	1,059,700		1,059,700	(7,688)	1,052,012			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,954,183	571,491	2,503,720	5,029,394		5,029,394	(85,289)	4,944,105			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 Champaign # 0048181 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				4
5	Telephone, TV & Radio in Resident Rooms	(24,736)	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	(308)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(116)	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	(747)	20		17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment	(4,137)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50,510)	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	(5,416)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,600)		$	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)	2,311	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,311		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (85,289)		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 Champaign

ID# 0048181

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Elminate Gifts & Flowers	$ (2,877)	20	1
2	To Offset Medical Records Income	(199)	10	2
3	To Elminate Lobbying & PAC Dues	(2,340)	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
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22				22
23				23
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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**	(5,416)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 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	(116)	0	0	0	0	0	0	0	0	0	0	(116)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(24,736)	187	0	0	0	0	0	0	0	0	0	(24,549)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(24,852)	187	0	0	0	0	0	0	0	0	0	(24,665)	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	(199)	19,531	0	0	0	0	0	0	0	0	0	19,332	10
10a	Therapy	0	0	5,630	0	0	0	0	0	0	0	0	5,630	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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**	(199)	19,531	5,630	0	0	0	0	0	0	0	0	24,962	16
	C. General Administration													
17	Administrative	0	(184,685)	1,447	0	0	0	0	0	0	0	0	(183,238)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(200)	13,209	0	0	0	0	0	0	0	0	0	13,009	19
20	Fees, Subscriptions & Promotions	(56,474)	655	0	0	0	0	0	0	0	0	0	(55,819)	20
21	Clerical & General Office Expenses	(5,567)	115,676	106	0	0	0	0	0	0	0	0	110,215	21
22	Employee Benefits & Payroll Taxes	0	16,698	1,007	0	0	0	0	0	0	0	0	17,705	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,393	57	0	0	0	0	0	0	0	0	5,450	24
25	Other Admin. Staff Transportation	0	5,534	164	0	0	0	0	0	0	0	0	5,698	25
26	Insurance-Prop.Liab.Malpractice	0	1,593	12	0	0	0	0	0	0	0	0	1,605	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(62,241)	(25,927)	2,793	0	0	0	0	0	0	0	0	(85,375)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,292)	(6,209)	8,423	0	0	0	0	0	0	0	0	(85,078)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 **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	1,245	0	0	0	0	0	0	0	0	0	1,245	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(308)	0	79	0	0	0	0	0	0	0	0	(229)	32
33	Real Estate Taxes	0	16	0	0	0	0	0	0	0	0	0	16	33
34	Rent-Facility & Grounds	0	5,891	0	0	0	0	0	0	0	0	0	5,891	34
35	Rent-Equipment & Vehicles	0	0	554	0	0	0	0	0	0	0	0	554	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(308)	7,152	633	0	0	0	0	0	0	0	0	7,477	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	(7,688)	0	0	0	0	0	0	0	0	(7,688)	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	(7,688)	0	0	0	0	0	0	0	0	(7,688)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,600)	943	1,368	0	0	0	0	0	0	0	0	(85,289)	45

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Engery, 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%	$ 187	$ 187	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	19,531	19,531	2
3	V	17	Management Fees	231,000	Bridgemark Healthcare, LLC	100.00%	46,315	(184,685)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	13,209	13,209	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	655	655	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	115,676	115,676	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	16,698	16,698	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,393	5,393	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,534	5,534	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,593	1,593	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,245	1,245	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	16	16	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	5,891	5,891	13
14	Total			$ 231,000			$ 231,943	$ * 943	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 Champaign # 0048181 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%	$ 554	$ 554	15
16	V								16
17	V								17
18	V								18
19	V	10a	Therapy		NW Rehab, LLC	100.00%	5,630	5,630	19
20	V	17	Admin Salaries		NW Rehab, LLC	100.00%	1,447	1,447	20
21	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	106	106	21
22	V	22	Employee Benefits		NW Rehab, LLC	100.00%	1,007	1,007	22
23	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	57	57	23
24	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	164	164	24
25	V	26	Insurance - Prop Liab., Malprac		NW Rehab, LLC	100.00%	12	12	25
26	V	32	Interest		NW Rehab, LLC	100.00%	79	79	26
27	V	39	Ancillary Service Ctr.	7,688	NW Rehab, LLC	100.00%		(7,688)	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			$ 7,688			$ 9,056	$ * 1,368	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 Champaign # 0048181 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 Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Hillsboro	Hillsboro, IL				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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	730,473	2.98	5.96	Distribution	$ 46,315	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	$ 46,315		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 Champaign # 0048181 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	$	21,558	$ 187	1
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	21,558	19,531	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788		21,558	46,315	3
4	19	Professional Fees	Resident Days	361,568	13	221,539		21,558	13,209	4
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991		21,558	655	5
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	21,558	93,080	6
7	21	Clercial & Office Supplies	Resident Days	361,568	13	378,981		21,558	22,596	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058		21,558	16,698	8
9	24	Seminars	Resident Days	361,568	13	90,455		21,558	5,393	9
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816		21,558	5,534	10
11	26	Insurance	Resident Days	361,568	13	26,711		21,558	1,593	11
12	30	Depreciation	Resident Days	361,568	13	20,874		21,558	1,245	12
13	33	Real Estate Taxes	Resident Days	361,568	13	269		21,558	16	13
14	34	Building Rent	Resident Days	361,568	13	98,805		21,558	5,891	14
15	35	Equipment Rental	Resident Days	361,568	13	9,286		21,558	554	15
16										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		$ 232,497	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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
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	9,023	$ 5,630	1
2	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	9,023	1,447	2
3	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456		9,023	106	3
4	22	Employee Benefits	Revenue	2,581,783	19	288,251		9,023	1,007	4
5	24	Travel & Seminar	Revenue	2,581,783	19	16,377		9,023	57	5
6	25	Other Admin Transp	Revenue	2,581,783	19	46,860		9,023	164	6
7	26	Insurance - Prop Liab. Malprac	Revenue	2,581,783	19	3,500		9,023	12	7
8	32	Interest	Revenue	2,581,783	19	22,721		9,023	79	8
9	10	Nursing & Med	Revenue	2,581,783	19	73		9,023		9
10	20	Dues & Subscriptions	Revenue	2,581,783	19	136		9,023		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		$ 8,502	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	51,829	6
7	Related Party Allocation										79	7
8												8
9	TOTAL Facility Related						$	$			$ 51,908	9
	B. Non-Facility Related*											
10	Interest Income Other		X								(308)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (308)	14
15	TOTALS (line 9+line14)						$	$			$ 51,600	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 Champaign # 0048181 **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.**	$ 36,316	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.)		$ 36,316	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 36,316	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.		$ 36,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012	35,282	8
2013	35,956	9
2014	36,282	10
2015	36,595	11
2016	36,316	12

36,316	Line 7, Real Estate Tax Portion of Lease Payments	
16	Bridgemark Healthcare Allocation	
36,332	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0048181

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.	45-20-22-282-005	Long Term Care	$ 36,316.44	$ 36,316.44
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,316.44	$ 36,316.44

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 Champaign # 0048181 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 1

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	Concrete			2006	2,907						10
11	Commercial Floor Covering			2006	5,183						11
12	Wall A/C Units			2006	3,347						12
13	Roofing - D & R Roofing			2007	20,600						13
14	Pipes			2007	8,346						14
15	Life Safety Detectors & Lighted Exit Sign			2007	3,871						15
16	A/C Units			2007	3,039						16
17	Heating & A/C Compressor & A/C Units			2008	7,072						17
18	Roof Top A/C & Roof Repairs			2008	7,347						18
19	Door, Sign & Emergency Back-up Lights			2009	4,174						19
20	Remodel Hall A - New Doors, flooring rails & upgrade nurses station			2009	14,343						20
21	Modern Tile			2010	4,243						21
22	Carpet/Tile			2010	9,457						22
23	Hot Water Heater			2011	6,504						23
24	Roof Top HVAC Unit			2012	6,700						24
25	Fire Alarm Panel			2013	7,938						25
26											26
27	Installed new phone/internet wiring throughout facility			2014	11,000	733	15	733		2,689	27
28	Lumber for handrails made and installed in the A & B Wings			2014	3,520	235	15	235		802	28
29	Install handrails, cabinets, sinks, doors, & carpet - A & B Wings			2014	6,190	412	15	412		1,376	29
30	DS - Emergency Light			2014	223	22	10	22		73	30
31	ARCH (Rehab) Unit - labor, doors, windows, drywall, paint, flooring, fire										31
32	(cont.) alarms, plumbing, architect fees - wings C & D converted			2016	618,036	30,902	20	30,902		33,477	32
33	Replace A/C System			2017	4,250	177	10	177		177	33
34	Install Eye Wash Station			2017	1,600	147	10	147		147	34
35	Paint, Flooring, New Shower, and Labor in Arch Unit			2017	35,575	1,779	20	1,779		1,779	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 - Leasehold Improvements:		$	$		$	$	$	37
38	New Office Build Out	2011	8,098		20	429	429	2,767	38
39	Conference Rm Chair Rail & Paint	2012	92		5	12	12	92	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 803,655	$ 34,407		$ 34,848	$ 441	$ 43,379	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 Champaign # 0048181 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	$ 212,145	$ 22,672	$ 23,476	$ 804	3-15	$ 52,165	71
72	Current Year Purchases	1,955	47	47		3-15	47	72
73	Fully Depreciated Assets	5,604					5,604	73
74								74
75	TOTALS	$ 219,704	$ 22,719	$ 23,523	$ 804		$ 57,816	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	Related Party Allocation - Bridgemark		2005	$ 792	$	$	$	4	$ 792	76
77										77
78										78
79										79
80	TOTALS			$ 792	$	$	$		$ 792	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,024,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 58,371	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,245	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 101,987	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 Champaign # 0048181 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: Champaign, Williamson, Franklin, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [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:		118		$ 320,603			3
4	Additions							4
5	Related Party Allocation - Bridgemark				5,891			5
6	Storage Rental				18,194			6
7	TOTAL		118		$ 344,688 **			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.	/2018	$ 294,000
13.	/2019	$ 294,000
14.	/2020	$ 294,000

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: $ 29,192 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 Champaign # 0048181 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

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		hrs							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				207,751		207,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					31,918		31,918	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				638,029			638,029	13
14	TOTAL			$		$ 638,029	$ 239,669		$ 877,698	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 Champaign **#** 0048181 **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	$ 3,563	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 257,126)	776,283		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	172,509		7
8	Accounts Receivable (owners or related parties)	703,550		8
9	Other(specify): Deposits	78,981		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,734,886	$	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	689,543		15
16	Equipment, at Historical Cost	199,152		16
17	Accumulated Depreciation (book methods)	(89,119)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	41,749		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 841,325	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,576,211	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,282,155	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,807		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,316		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	972		36
37	Accrued Provider Assessment	19,285		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,444,635	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,250		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 32,250	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,476,885	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,099,326	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,576,211	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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**	$ 1,736,239	1
2	Restatements (describe):		2
3	**Prior Year Adjustments**	4,036	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,740,275	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(640,949)	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)**	$ (640,949)	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)**	$ 1,099,326	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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	$ 4,363,120	1
2	Discounts and Allowances for all Levels	(199,036)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,164,084	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	209,980	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 209,980	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		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	2,747	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	308	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 308	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records	199	28
28a	Miscellaneous Income	11,127	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,326	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,388,445	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	729,544	31
32	Health Care	1,585,711	32
33	General Administration	1,141,733	33
	B. Capital Expense		
34	Ownership	512,706	34
	C. Ancillary Expense		
35	Special Cost Centers	885,386	35
36	Provider Participation Fee	174,314	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,029,394	40
41	**Income before Income Taxes (line 30 minus line 40)****	(640,949)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (640,949)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,236,748	44
45	Private Pay - Net Inpatient Revenue	801,168	45
46	Medicare - Net Inpatient Revenue	1,336,386	46
47	Other-(specify) Insurance	708,411	47
48	Other-(specify) Hospice	81,371	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,164,084	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 Champaign # 0048181 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	1,325	1,517	$ 55,255	$ 36.42	1
2	Assistant Director of Nursing	719	852	28,063	32.94	2
3	Registered Nurses	9,839	10,416	308,788	29.65	3
4	Licensed Practical Nurses	11,728	12,334	325,761	26.41	4
5	CNAs & Orderlies	40,418	43,274	585,978	13.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,746	2,045	35,755	17.48	8
9	Activity Director					9
10	Activity Assistants	1,946	2,120	33,073	15.60	10
11	Social Service Workers	1,871	2,028	48,126	23.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,140	11,975	161,910	13.52	15
16	Dishwashers					16
17	Maintenance Workers	1,741	2,038	41,902	20.56	17
18	Housekeepers	7,111	7,616	83,758	11.00	18
19	Laundry	3,422	3,798	35,423	9.33	19
20	Administrator	1,714	1,867	95,215	51.00	20
21	Assistant Administrator	1,970	2,228	53,011	23.79	21
22	Other Administrative	336	344	9,418	27.38	22
23	Office Manager	1,429	1,646	52,747	32.05	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,455	106,098	$ 1,954,183 *	$ 18.42	34

* 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		$ 8,610	1,3	35
36	Medical Director		20,000	9,3	36
37	Medical Records Consultant		2,263	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,123	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		4,161	11,3	44
45	Social Service Consultant		2,857	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,014		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Stephenson	Administrator	0	$ 15,049
Jason Young	Administrator	0	80,166
Brenda Dively	Asst. Admin.	0	53,011
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 148,226

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 231,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 231,000

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 1,093
Personal Planners, Inc.	Unemployment Consulting	1,666
National Research Company	Surveys	236
Paycom Payroll	Payroll Processing	11,921
	Bad Debt Collection Fees	200
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 15,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,255
Unemployment Compensation Insurance	37,694
FICA Taxes	147,556
Employee Health Insurance	20,019
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,224
Employee Benefits	2,442
Related Party Allocation - Bridgemark	16,698
Related Party Allocation - NW Rehab	1,007
TOTAL (agree to Schedule V, line 22, col.8)	$ 278,895

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	$
Advertising: Employee Recruitment	7,705
Health Care Worker Background Check	584
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	9,207
Late Fees	54,137
Miscellaneous Licenses & Fees	633
Advertising	50,510
Related Party Allocation - Bridgemark	655
Less: Public Relations Expense	( )
Non-allowable advertising	(50,510)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 72,921

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,054
Seminar Expense	920
Related Party Allocation - Bridgemark	5,393
Related Party Allocation - NW Rehab	57
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,424

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 $5,448**

(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. $ **28,235** 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. $ **174,314**
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? **No** Indicate the amount. $ **N/A**

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

	Description	
16A	Nursing Equipment	11,546
16B	Copier Lease	6,361
16C	Respiratory Equipment	490
16D	Related Party Allocation - Bridgemark Healthcare	554
16E	Computer & Printer Rental	10,241
		29,192