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: 0046672

Facility Name: Helia Healthcare of Energy

Address: 210 E College Bx 519 (Number) Energy (City) 62933 (Zip Code)

County: Williamson

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 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 Energy # 0046672 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	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	7	Intermediate (ICF)	7	2,555	3
4	48	Intermediate/DD	48	17,520	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	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	9,330	2,744	11,522	23,596	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,330	2,744	11,522	23,596	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.51%

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 12/01/03

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 8,491

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 Energy # 0046672 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	168,547	22,977	9,539	201,063		201,063		201,063			1
2	Food Purchase		154,264		154,264		154,264	(89)	154,175			2
3	Housekeeping	111,523	25,841	9,984	147,348		147,348		147,348			3
4	Laundry	14,998	9,042	48,000	72,040		72,040	(10,676)	61,364			4
5	Heat and Other Utilities			107,165	107,165		107,165	(3,880)	103,285			5
6	Maintenance	45,231	13,254	53,536	112,021		112,021	49,411	161,432			6
7	Other (specify):*											7
8	TOTAL General Services	340,299	225,378	228,224	793,901		793,901	34,766	828,667			8
	B. Health Care and Programs											
9	Medical Director			16,504	16,504		16,504		16,504			9
10	Nursing and Medical Records	1,679,428	125,184	16,948	1,821,560		1,821,560	21,377	1,842,937			10
10a	Therapy		3,112		3,112		3,112	1,015	4,127			10a
11	Activities	22,706	5,485	4,619	32,810		32,810	(44)	32,766			11
12	Social Services	35,490	150	2,463	38,103		38,103		38,103			12
13	CNA Training											13
14	Program Transportation			159	159		159		159			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,737,624	133,931	40,693	1,912,248		1,912,248	22,348	1,934,596			16
	C. General Administration											
17	Administrative	134,734		329,700	464,434		464,434	(278,746)	185,688			17
18	Directors Fees											18
19	Professional Services			36,457	36,457		36,457	15,203	51,660			19
20	Dues, Fees, Subscriptions & Promotions			135,198	135,198		135,198	(55,823)	79,375			20
21	Clerical & General Office Expenses	113,938	31,084	110,871	255,893		255,893	123,919	379,812			21
22	Employee Benefits & Payroll Taxes			340,498	340,498		340,498	31,295	371,793			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,847	11,847		11,847	5,913	17,760			24
25	Other Admin. Staff Transportation			7,495	7,495		7,495	15,707	23,202			25
26	Insurance-Prop.Liab.Malpractice			105,048	105,048		105,048	2,330	107,378			26
27	Other (specify):*											27
28	TOTAL General Administration	248,672	31,084	1,077,114	1,356,870		1,356,870	(140,202)	1,216,668			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,326,595	390,393	1,346,031	4,063,019		4,063,019	(83,088)	3,979,931			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy #0046672 Report Period Beginning: 01/01/17 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			23,571	23,571		23,571	6,310	29,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144,550	144,550		144,550	(2,708)	141,842			32
33	Real Estate Taxes			73,954	73,954		73,954	1,179	75,133			33
34	Rent-Facility & Grounds			370,404	370,404		370,404	8,548	378,952			34
35	Rent-Equipment & Vehicles			52,917	52,917		52,917	67	52,984			35
36	Other (specify):*											36
37	**TOTAL Ownership**			665,396	665,396		665,396	13,396	678,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		454,451	1,099,123	1,553,574		1,553,574	(1,627)	1,551,947			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,606	166,606		166,606		166,606			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		454,451	1,265,729	1,720,180		1,720,180	(1,627)	1,718,553			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,326,595	844,844	3,277,156	6,448,595		6,448,595	(71,319)	6,377,276			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(44)	11		4
5	Telephone, TV & Radio in Resident Rooms	(13,071)	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	(2,722)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(89)	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	(294)	20		17
18	Fines and Penalties	(103)	21		18
19	Entertainment	(3,801)	21		19
20	Contributions	(780)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(570)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(49,144)	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	(7,102)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (77,720)		$	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)	6,401	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 6,401		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (71,319)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Energy

ID# 0046672

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (2,892)	20	1
2	Eliminate Lobbying & PAC Dues	(2,220)	20	2
3	Eliminate 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**	(7,102)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	(89)	0	0	0	0	0	0	0	0	0	0	(89)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(10,676)	0	0	0	0	0	0	0	0	(10,676)	4
5	Heat and Other Utilities	(13,071)	205	8,986	0	0	0	0	0	0	0	0	(3,880)	5
6	Maintenance	0	0	49,411	0	0	0	0	0	0	0	0	49,411	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,160)	205	47,721	0	0	0	0	0	0	0	0	34,766	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	21,377	0	0	0	0	0	0	0	0	0	21,377	10
10a	Therapy	0	0	1,015	0	0	0	0	0	0	0	0	1,015	10a
11	Activities	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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**	(44)	21,377	1,015	0	0	0	0	0	0	0	0	22,348	16
	C. General Administration													
17	Administrative	0	(279,007)	261	0	0	0	0	0	0	0	0	(278,746)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(570)	14,458	1,315	0	0	0	0	0	0	0	0	15,203	19
20	Fees, Subscriptions & Promotions	(56,540)	717	0	0	0	0	0	0	0	0	0	(55,823)	20
21	Clerical & General Office Expenses	(4,684)	126,612	1,991	0	0	0	0	0	0	0	0	123,919	21
22	Employee Benefits & Payroll Taxes	0	18,277	13,018	0	0	0	0	0	0	0	0	31,295	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,903	10	0	0	0	0	0	0	0	0	5,913	24
25	Other Admin. Staff Transportation	0	6,057	9,650	0	0	0	0	0	0	0	0	15,707	25
26	Insurance-Prop.Liab.Malpractice	0	1,743	585	2	0	0	0	0	0	0	0	2,330	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(61,794)	(105,240)	26,830	2	0	0	0	0	0	0	0	(140,202)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,998)	(83,658)	75,566	2	0	0	0	0	0	0	0	(83,088)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy # 0046672 **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	1,362	4,948	0	0	0	0	0	0	0	0	6,310	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,722)	0	0	14	0	0	0	0	0	0	0	(2,708)	32
33	Real Estate Taxes	0	18	1,161	0	0	0	0	0	0	0	0	1,179	33
34	Rent-Facility & Grounds	0	6,448	2,100	0	0	0	0	0	0	0	0	8,548	34
35	Rent-Equipment & Vehicles	0	0	67	0	0	0	0	0	0	0	0	67	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,722)	7,828	8,276	14	0	0	0	0	0	0	0	13,396	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	(1,627)	0	0	0	0	0	0	0	(1,627)	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	(1,627)	0	0	0	0	0	0	0	(1,627)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(77,720)	(75,830)	83,842	(1,611)	0	0	0	0	0	0	0	(71,319)	45

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 Champaign	Champaign, 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%	$ 205	$ 205	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	21,377	21,377	2
3	V	17	Management Fees	329,700	Bridgemark Healthcare, LLC	100.00%	50,693	(279,007)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	14,458	14,458	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	717	717	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	126,612	126,612	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	18,277	18,277	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,903	5,903	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	6,057	6,057	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,743	1,743	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,362	1,362	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	18	18	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	6,448	6,448	13
14	Total			$ 329,700			$ 253,870	$ * (75,830)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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%	$ 606	$ 606	15
16	V								16
17	V	30	Depreciation		Bridgemark Medical Supply	100.00%	1,326	1,326	17
18	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	157	157	18
19	V	35	Equipment Rental	777	Bridgemark Medical Supply	100.00%		(777)	19
20	V	4	Laundry	48,000	Helia Healthcare Services	100.00%	37,324	(10,676)	20
21	V	5	Utilities		Helia Healthcare Services	100.00%	8,986	8,986	21
22	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	52,411	49,411	22
23	V	19	Professional Services		Helia Healthcare Services	100.00%	1,315	1,315	23
24	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,972	1,972	24
25	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	12,836	12,836	25
26	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	9,620	9,620	26
27	V	26	Insurance		Helia Healthcare Services	100.00%	585	585	27
28	V	30	Depreciation		Helia Healthcare Services	100.00%	3,622	3,622	28
29	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,161	1,161	29
30	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	1,943	1,943	30
31	V	35	Rent - Vehicle		Helia Healthcare Services	100.00%	238	238	31
32	V								32
33	V	10a	Therapy		NW Rehab, LLC	100.00%	1,015	1,015	33
34	V	17	Admin Salaries		NW Rehab, LLC	100.00%	261	261	34
35	V	21	Salaries - Other		NW Rehab, LLC	100.00%	19	19	35
36	V	22	Employee Benefits & Payroll Taxes		NW Rehab, LLC	100.00%	182	182	36
37	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	10	10	37
38	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	30	30	38
39	Total			$ 51,777			$ 135,619	$ * 83,842	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	26	Insurance - Prop, Liab, Malprac	$	NW Rehab, LLC	100.00%	$ 2	$ 2	15
16	V	32	Interest		NW Rehab, LLC	100.00%	14	14	16
17	V	39	Ancillary Service Centers	1,627	NW Rehab, LLC	100.00%		(1,627)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								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			$ 1,627			$ 16	$ * (1,611)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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 Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Florissant	Florissant, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	726,095	3.26	6.53	Distribution	$ 50,693	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	$ 50,693		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	$	23,596	$ 205	1
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	23,596	21,377	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788		23,596	50,693	3
4	19	Professional Fees	Resident Days	361,568	13	221,539		23,596	14,458	4
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991		23,596	717	5
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	23,596	101,880	6
7	21	Clercial & Office Supplies	Resident Days	361,568	13	378,981		23,596	24,732	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058		23,596	18,277	8
9	24	Seminars	Resident Days	361,568	13	90,455		23,596	5,903	9
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816		23,596	6,057	10
11	26	Insurance	Resident Days	361,568	13	26,711		23,596	1,743	11
12	30	Depreciation	Resident Days	361,568	13	20,874		23,596	1,362	12
13	33	Real Estate Taxes	Resident Days	361,568	13	269		23,596	18	13
14	34	Building Rent	Resident Days	361,568	13	95,732		23,596	6,247	14
15	34	Storage Unit Rent	Resident Days	361,568	13	3,073		23,596	201	15
16	35	Equipment Rental	Resident Days	361,568	13	9,286		23,596	606	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		$ 254,476	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	$	5,313	$ 1,326	1
2	34	Building Rent	Revenue	70,485	7	2,079		5,313	157	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	$		$ 1,483	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	51,000	$ 37,324	1
2	5	Utilities	Revenue	178,000	3	31,363		51,000	8,986	2
3	6	Maintenance	Revenue	178,000	3	182,925	182,925	51,000	52,411	3
4	19	Professional Services	Revenue	178,000	3	4,588		51,000	1,315	4
5	21	Clerical & Office Supplies	Revenue	178,000	3	6,882		51,000	1,972	5
6	22	Payroll Taxes & Emp Benefits	Revenue	178,000	3	44,799		51,000	12,836	6
7	25	Other Admin Transportation	Revenue	178,000	3	33,574		51,000	9,620	7
8	26	Insurance	Revenue	178,000	3	2,042		51,000	585	8
9	30	Depreciation	Revenue	178,000	3	12,642		51,000	3,622	9
10	33	Real Estate Taxes	Revenue	178,000	3	4,052		51,000	1,161	10
11	34	Rent - Facility	Revenue	178,000	3	6,780		51,000	1,943	11
12	35	Rent - Vehicle	Revenue	178,000	3	829		51,000	238	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		$ 132,013	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	10	Nursing & Medical Records	Revenue	2,581,783	19	$ 73	$	1,627	$	1
2	10a	Therapy	Revenue	2,581,783	19	1,610,941	1,610,941	1,627	1,015	2
3	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	1,627	261	3
4	20	Dues & Subscriptions	Revenue	2,581,783	19	136		1,627		4
5	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456		1,627	19	5
6	22	Employee Benefits	Revenue	2,581,783	19	288,251		1,627	182	6
7	24	Travel & Seminar	Revenue	2,581,783	19	16,377		1,627	10	7
8	25	Other Admin Transp	Revenue	2,581,783	19	46,860		1,627	30	8
9	26	Insurance - Prop, Liab, Malprac	Revenue	2,581,783	19	3,500		1,627	2	9
10	32	Interest	Revenue	2,581,783	19	22,721		1,627	14	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		$ 1,533	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 I, LLC		X	Line of Credit		10/22/09				Variable	144,550	6
7												7
8	Related Party Allocation										14	8
9	TOTAL Facility Related						$	$			$ 144,564	9
	B. Non-Facility Related*											
10	Interest Income Other		X								(2,722)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,722)	14
15	TOTALS (line 9+line14)						$	$			$ 141,842	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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.**	$ 72,950	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 72,929	2
3. Under or (over) accrual (line 2 minus line 1).		$ (21)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,975	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.		$ 73,954	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	33,547	8
	2013	68,822	9
	2014	70,423	10
	2015	72,073	11
	2016	72,929	12

73,954 Line 7, Real Estate Tax Portion of Lease Payment
18 Bridgemark Healthcare Allocation
1,161 Helia Healthcare Allocation
75,133 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 Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 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.	06-06-227-019	Long Term Care	$ 72,929.16	$ 72,929.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,929.16	$ 72,929.16

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 Energy # 0046672 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,850 B. General Construction Type: Exterior Brick Veneer Frame Masonry Brick Number of Stories 1

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation - Helia Healthcare			$ 1,435	1
2					2
3	TOTALS			$ 1,435	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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		$ 38,260	$	25	$ 1,913	$ 1,913	$ 6,786	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	"C" Wing Signs			2004	1,752						10
11	Handrail Molding			2004	1,000						11
12	Wallpaper			2004	1,740						12
13	Wallpaper			2004	1,062						13
14	Room Signs			2004	1,357						14
15	Paint Boarder			2004	2,253						15
16	Door Handles & Knobs			2004	729						16
17	Boarder for B Wing			2004	582						17
18	Wallpaper for C Wing			2004	1,107						18
19	Handrails, Brackts			2004	1,093						19
20	Wire Smoke detectors			2004	572						20
21	Door Knobs B & C Wing			2004	766						21
22	2 Wall A/C Units			2005	1,035						22
23	Roof Top HVAC Unit			2006	13,757						23
24	5 Wall A/C			2006	3,242						24
25	Smoke Detectors			2006	749						25
26	Fence			2006	573						26
27	Glass Door & Install			2007	1,210						27
28	Roof Top HVAC Unit			2007	17,623						28
29	80 Gallon Water Heater			2007	2,829						29
30	Trailor for Resident Smokers			2008	1,295						30
31	Doors			2008	8,553						31
32	Wall Air Conditioner			2008	3,040						32
33	3 Wall A/C Units			2009	3,686						33
34	New Doors, Flooring, Wallcovering for entrance & Wing			2009	56,401						34
35	Roof Repair			2009	2,000						35
36	Call Cords			2009	1,255						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	Exterior Brickwork Improvements	2010	$ 7,712	$		$	$	$	37
38	New Asphalt Parking Lot	2010	22,840						38
39	Heat/Water Pump System	2010	9,800						39
40	A/C Compressor Replacement	2010	1,999						40
41	Fire Protection System: Arch Wing	2010	7,971						41
42	15 Heat/Cool Wall Units	2010	7,753						42
43	10 Heat/Cool Wall Units	2010	5,530						43
44	Phone System	2010	17,144						44
45	S Hall (22rms) - New Doors, windows, bathrooms, paint, drywall	2011	56,140						45
46	W Hall (6rms) - new doors,windows, bathrooms, paint, drywall	2011	22,456						46
47	Nursing Station Improve-new cabinets, counter, wiring, floor	2011	22,456						47
48	Dining Room - Flooring, drywall, lighting fixutres, paint	2011	33,684						48
49	Resident lounge area -electrical, lighting, fixtures, drywall, paint	2011	22,456						49
50	Resident Kitchen Area - New Sinks, flooring, wiring, drywall, pain	2011	11,228						50
51	Therapy Room - Flooring, drywall, paint, lighting, window, labor	2011	22,456						51
52	2 Shower Rooms - Tile, Shower heads, fixutres, paint, new plumbi	2011	33,684						52
53	Arch (Rehab) Unit - Labor, doors, windows, drywall, paint, floorir	2011	70,667						53
54	(cont.) fire alarms, plumbing, architect fees								54
55	Exterior Brickwork Improvements	2011	3,600						55
56	21 Wall A/C Units	2012	8,691						56
57	New Central Air unit on A Wing	2012	2,700						57
58	Flooring	2012	1,780						58
59	Door Monitors & Keypads	2012	1,707						59
60	Heat/Cool Wall Units	2012	4,580						60
61	Bed Additions in ARCH Unit	2013	34,951						61
62	Heating/Cool Units	2013	3,919						62
63									63
64	4 A/C Units	2014	2,586	517	5	517		1,595	64
65	Tile, paint, vanities, toliets - A Wing	2014	3,971	397	10	397		1,555	65
66	Windows, Tile Door & Vanities - B Wing	2014	3,584	358	10	358		1,314	66
67	A Wing Nurses Station	2014	1,450	145	10	145		495	67
68	Windows, laminate tops, paint, tile B Wing	2014	15,282	1,019	15	1,019		3,056	68
69	Kitchen, wiring install	2014	990	99	10	99		388	69
70	TOTAL (lines 4 thru 69)		$ 635,288	$ 2,535		$ 4,448	$ 1,913	$ 15,189	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	
1	Totals from Page 12A, Carried Forward		$ 635,288	$ 2,535		$ 4,448	$ 1,913	$ 15,189	1
2	CTS Tech Phone Line Upgrade/Cabeling Install	2014	5,113	511	10	511		1,980	2
3	Security I - Alarm System Install	2014	1,950	195	10	195		666	3
4	Windows	2014	925	93	10	93		300	4
5	A Wing Remodel Floor/Tile/Paint	2015	5,594	373	15	373		1,088	5
6	Kitchen Flooring & Laminate Countertops	2015	5,272	352	15	352		820	6
7	Vinyl Tile - A Wing	2016	9,121	912	10	912		1,672	7
8	Fire Alarm Replacement & 12 yr Suppression	2016	5,293	529	10	529		926	8
9	ARCH Remodel - labor, doors, windows, drywall, paint,								9
10	(cont.) flooring, fire alarms, plumbing, architect fees	2016	99,999	5,000	20	5,000		10,000	10
11	Front Door	2017	3,217	241	10	241		241	11
12	Therapy Room/ARCH Remodel - paint, trim, doors	2017	13,970	375	20	375		375	12
13									13
14									14
15									15
16									16
17	Related Party Allocation - Bridgemark Healthcare LLC								17
18	New Office Build-Out	2011	8,863		20	469	469	3,029	18
19	Conference Rm Chair Rail & Paint	2012	100		5	13	13	100	19
20									20
21									21
22	Related Party Allocation - Helia Healthcare								22
23	Water & Sewer Pipe Installation	2006	544		20	27	27	311	23
24	Plumbing & Heating Installation	2006	652		20	33	33	372	24
25	A/C Unit - 4 Ton	2007	1,570		10	52	52	1,570	25
26	400 Gal. Water Storage Tank	2016	4,430		10	443	443	628	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 801,901	$ 11,116		$ 14,066	$ 2,950	$ 39,267	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	$ 99,356	$ 9,531	$ 12,653	$ 3,122	3-15	$ 49,260	71
72	Current Year Purchases	11,011	439	677	238	3-15	677	72
73	Fully Depreciated Assets	22,631					22,631	73
74								74
75	TOTALS	$ 132,998	$ 9,970	$ 13,330	$ 3,360		$ 72,568	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2014	2014	$ 9,938	$ 2,485	$ 2,485	$	4	$ 9,317	76
77	Related Party Allocation - Bridgemark		2005	867				4	867	77
78	Related Party Allocation - Helia		2006	1,923				4	1,923	78
79										79
80	TOTALS			$ 12,728	$ 2,485	$ 2,485	$		$ 12,107	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)	$ 949,062	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,571	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,881	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,310	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 123,942	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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:		139		$ 370,404			3
4	Additions							4
5	Related Party Allocations				8,548			5
6								6
7	TOTAL		139		$ 378,952 **			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	$ 357,000
13.	/2019	$ 357,000
14.	/2020	$ 357,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 52,984 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	10a,2	hrs	$		$	$ 151		$ 151	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				2,961		2,961	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				418,298		418,298	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					36,153		36,153	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				1,099,123			1,099,123	13
14	TOTAL			$		$ 1,099,123	$ 457,563		$ 1,556,686	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Energy **#** 0046672 **Report Period Beginning:** 01/01/17 **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	$ 4,541	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,457)	1,600,476		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,224		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	89,250		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,697,491	$	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	174,807		15
16	Equipment, at Historical Cost	91,462		16
17	Accumulated Depreciation (book methods)	(72,437)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	73,975		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 267,807	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,965,298	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,319,029	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,083		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,981		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,975		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessments	15,903		36
37	Due to Related Parties	264,307		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,825,278	$	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	180,106		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 180,106	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,005,384	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,040,086)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,965,298	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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**	$ (1,122,058)	1
2	Restatements (describe):		2
3	**Prior year adjustments made after cost report issued**	(49)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,122,107)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	82,021	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)**	$ 82,021	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)**	$ (1,040,086)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	$ 6,489,313	1
2	Discounts and Allowances for all Levels	(103,714)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,385,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,745	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 114,745	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	44	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)**	$ 44	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,722	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,722	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	27,506	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,506	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,530,616	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	793,901	31
32	Health Care	1,912,248	32
33	General Administration	1,356,870	33
	B. Capital Expense		
34	Ownership	665,396	34
	C. Ancillary Expense		
35	Special Cost Centers	1,553,574	35
36	Provider Participation Fee	166,606	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,448,595	40
41	**Income before Income Taxes (line 30 minus line 40)****	82,021	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 82,021	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,364,824	44
45	Private Pay - Net Inpatient Revenue	406,383	45
46	Medicare - Net Inpatient Revenue	3,918,966	46
47	Other-(specify) Inusrance	686,665	47
48	Other-(specify) Hospice	8,761	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,385,599	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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	1,948	2,102	$ 93,519	$ 44.49	1
2	Assistant Director of Nursing	1,990	2,032	63,550	31.27	2
3	Registered Nurses	14,970	15,794	455,153	28.82	3
4	Licensed Practical Nurses	12,481	13,442	305,917	22.76	4
5	CNAs & Orderlies	46,614	49,044	617,230	12.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	959	1,104	16,832	15.25	8
9	Activity Director					9
10	Activity Assistants	2,026	2,137	22,706	10.63	10
11	Social Service Workers	1,878	2,103	35,490	16.88	11
12	Dietician					12
13	Food Service Supervisor	1,741	1,941	32,031	16.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,580	12,141	136,516	11.24	15
16	Dishwashers					16
17	Maintenance Workers	1,948	2,119	45,231	21.35	17
18	Housekeepers	9,008	9,549	111,523	11.68	18
19	Laundry	1,522	1,522	14,998	9.85	19
20	Administrator	2,017	2,131	85,653	40.19	20
21	Assistant Administrator	2,046	2,302	49,081	21.32	21
22	Other Administrative					22
23	Office Manager	1,931	2,132	46,242	21.69	23
24	Clerical	1,802	1,997	67,696	33.90	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)	7,571	8,198	106,038	12.93	30
31	Medical Records	1,456	1,585	21,189	13.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,488	133,375	$ 2,326,595 *	$ 17.44	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		$ 9,539	1,3	35
36	Medical Director		16,504	9,3	36
37	Medical Records Consultant		3,558	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,127	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		4,619	11,3	44
45	Social Service Consultant		2,463	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,810		49

C. CONTRACT NURSES

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yolanda Fisher	Administrator	0	$ 85,653
Judy Minor	Asst. Admin	0	49,081
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,734

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 329,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 329,700

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 1,093
Personnel Planners	Unemployment Consulting	1,815
Much Shelist	Legal Fees	13,974
Sauter-Sullivan LLC	Legal Fees	4,308
Williamson County Clerk	Legal Fees	25
Ashman and Stein	Legal - IPG	119
Stein Law Offices	Legal Fees	405
Kramer & Frank	Collection fees - eliminated	570
Paycom Payroll, LLC	Payroll Processing	14,148
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 36,457

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,604
Unemployment Compensation Insurance	40,614
FICA Taxes	176,636
Employee Health Insurance	37,036
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	5,607
Employee Benefits	369
Other Employee Benefits	3,632
Related Party Allocation - Bridgemark	18,277
Related Party Allocation - Helia	12,836
Related Party Allocation - NW Rehab	182
TOTAL (agree to Schedule V, line 22, col.8)	$ 371,793

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	7,890
Health Care Worker Background Check	6,933
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	7,668
Late Fees	54,019
Miscellaneous Licenses & Fees	158
Advertising	49,144
Related Party Allocations	717
Less: Public Relations Expense	( )
Non-allowable advertising	(49,144)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,375

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,959
Seminar Expense	1,888
Related Party Allocation - Bridgemark	5,903
Related Party Allocation - NW Rehab	10
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,760

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/17 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 $5,168**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,766** 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. $ **166,606**
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. $ **44**

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

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

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

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

Helia Healthcare of Energy
Attachment to Schedule XII B
Equipment Rentals
12/31/2017

	Description	
16A	Nursing Equipment	28,724
16B	Copier Lease	11,335
16C	Dietary Equipment	144
16D	Related Party Allocation - Bridgemark Healthcare	606
16E	Related Party Allocation - Helia Healthcare	238
16F	Computer Lease	10,646
16G	Storage Rent	1,291
		52,984