FOR BHF USE

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

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.

I. IDPH License ID Number: 0050757

Facility Name: Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab

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

County: Richland

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 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) Director of Corporate Accounting and IT Systems

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 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 Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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	21,172	2,629	5,072	28,873	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,172	2,629	5,072	28,873	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.04%

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 4/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 4,664

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 Olney, L.L.C. d/b/a Richl # 0050757 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	172,370	15,097	7,550	195,017		195,017		195,017			1
2	Food Purchase		154,492		154,492		154,492	(70)	154,422			2
3	Housekeeping	149,625	27,407	3,429	180,461		180,461		180,461			3
4	Laundry	49,895	20,542	8,129	78,566		78,566		78,566			4
5	Heat and Other Utilities			121,168	121,168		121,168	(12,503)	108,665			5
6	Maintenance	3,014	6,267	56,768	66,049		66,049		66,049			6
7	Other (specify):*											7
8	TOTAL General Services	374,904	223,805	197,044	795,753		795,753	(12,573)	783,180			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,210,004	122,494	23,389	1,355,887		1,355,887	25,963	1,381,850			10
10a	Therapy	24,040	600		24,640		24,640	1,067	25,707			10a
11	Activities	24,782	14,810	4,464	44,056		44,056	(459)	43,597			11
12	Social Services	35,453	12	2,580	38,045		38,045		38,045			12
13	CNA Training											13
14	Program Transportation			1,152	1,152		1,152		1,152			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,294,279	137,916	43,585	1,475,780		1,475,780	26,571	1,502,351			16
	C. General Administration											
17	Administrative	61,105		267,300	328,405		328,405	(204,996)	123,409			17
18	Directors Fees											18
19	Professional Services			20,396	20,396		20,396	17,184	37,580			19
20	Dues, Fees, Subscriptions & Promotions			212,274	212,274		212,274	(45,063)	167,211			20
21	Clerical & General Office Expenses	41,726	24,125	128,853	194,704		194,704	151,073	345,777			21
22	Employee Benefits & Payroll Taxes			243,835	243,835		243,835	22,555	266,390			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,368	1,368		1,368	7,234	8,602			24
25	Other Admin. Staff Transportation			1,413	1,413		1,413	7,443	8,856			25
26	Insurance-Prop.Liab.Malpractice			89,306	89,306		89,306	2,135	91,441			26
27	Other (specify):*											27
28	TOTAL General Administration	102,831	24,125	964,745	1,091,701		1,091,701	(42,435)	1,049,266			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,772,014	385,846	1,205,374	3,363,234		3,363,234	(28,437)	3,334,797			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 Olney, L.L.C. d/b/a Richland Care and R #0050757 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,742	34,742		34,742	3,644	38,386			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			383,101	383,101		383,101	15	383,116			32
33	Real Estate Taxes			62,786	62,786		62,786	21	62,807			33
34	Rent-Facility & Grounds			741,106	741,106		741,106	8,124	749,230			34
35	Rent-Equipment & Vehicles			8,810	8,810		8,810	(7,945)	865			35
36	Other (specify):*											36
37	TOTAL Ownership			1,230,545	1,230,545		1,230,545	3,859	1,234,404			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,230	688,882	846,112		846,112	(1,620)	844,492			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,753	214,753		214,753		214,753			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,230	903,635	1,060,865		1,060,865	(1,620)	1,059,245			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,772,014	543,076	3,339,554	5,654,644		5,654,644	(26,198)	5,628,446			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 Olney, L.L.C. d/b/a Richland Care an # 0050757 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	(459)	11		4
5	Telephone, TV & Radio in Resident Rooms	(12,754)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment	(2,445)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(507)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(43,538)	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	(2,598)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,801)		$	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)	37,603	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 37,603		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (26,198)		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 Olney, L.L.C. d/b/a Richland Care and Rehab

ID# 0050757

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (1,553)	20	1
2	Eliminate Lobbying & PAC Dues	(2,340)	20	2
3	Offset Medical Record Income	(195)	10	3
4	Record IDPH License Fee paid in 2016	1,990	20	4
5	Eliminate Chamber of Commerce Fees	(500)	20	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**	(2,598)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and R # 0050757 **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	(70)	0	0	0	0	0	0	0	0	0	0	(70)	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	(12,754)	251	0	0	0	0	0	0	0	0	0	(12,503)	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**	(12,824)	251	0	0	0	0	0	0	0	0	0	(12,573)	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	(195)	26,158	0	0	0	0	0	0	0	0	0	25,963	10
10a	Therapy	0	0	1,067	0	0	0	0	0	0	0	0	1,067	10a
11	Activities	(459)	0	0	0	0	0	0	0	0	0	0	(459)	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**	(654)	26,158	1,067	0	0	0	0	0	0	0	0	26,571	16
	C. General Administration													
17	Administrative	0	(205,270)	274	0	0	0	0	0	0	0	0	(204,996)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(507)	17,691	0	0	0	0	0	0	0	0	0	17,184	19
20	Fees, Subscriptions & Promotions	(45,941)	878	0	0	0	0	0	0	0	0	0	(45,063)	20
21	Clerical & General Office Expenses	(3,875)	154,928	20	0	0	0	0	0	0	0	0	151,073	21
22	Employee Benefits & Payroll Taxes	0	22,364	191	0	0	0	0	0	0	0	0	22,555	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,223	11	0	0	0	0	0	0	0	0	7,234	24
25	Other Admin. Staff Transportation	0	7,412	31	0	0	0	0	0	0	0	0	7,443	25
26	Insurance-Prop.Liab.Malpractice	0	2,133	2	0	0	0	0	0	0	0	0	2,135	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(50,323)	7,359	529	0	0	0	0	0	0	0	0	(42,435)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,801)	33,768	1,596	0	0	0	0	0	0	0	0	(28,437)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and F # 0050757 **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	1,667	1,977	0	0	0	0	0	0	0	0	3,644	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	15	0	0	0	0	0	0	0	0	15	32
33	Real Estate Taxes	0	21	0	0	0	0	0	0	0	0	0	21	33
34	Rent-Facility & Grounds	0	7,890	234	0	0	0	0	0	0	0	0	8,124	34
35	Rent-Equipment & Vehicles	0	0	(7,945)	0	0	0	0	0	0	0	0	(7,945)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	9,578	(5,719)	0	0	0	0	0	0	0	0	3,859	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	(1,620)	0	0	0	0	0	0	0	0	(1,620)	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	(1,620)	0	0	0	0	0	0	0	0	(1,620)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,801)	43,346	(5,743)	0	0	0	0	0	0	0	0	(26,198)	45

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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 Benton	Benton, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Belleville	Belleville, 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%	$ 251	$ 251	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	26,158	26,158	2
3	V	17	Management Fees	267,300	Bridgemark Healthcare, LLC	100.00%	62,030	(205,270)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	17,691	17,691	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	878	878	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	154,928	154,928	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	22,364	22,364	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,223	7,223	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	7,412	7,412	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,133	2,133	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,667	1,667	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	21	21	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,890	7,890	13
14	Total			$ 267,300			$ 310,646	$ * 43,346	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 Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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%	$ 742	$ 742	15
16	V								16
17	V								17
18	V								18
19	V	30	Depreciation		Bridgemark Medical Supply	100.00%	1,977	1,977	19
20	V	34	Building Rent		Bridgemark Medical Supply	100.00%	234	234	20
21	V	35	Equipment Rental	8,687	Bridgemark Medical Supply	100.00%		(8,687)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	10a	Therapy		NW Rehab, LLC	100.00%	1,067	1,067	26
27	V	17	Admin Salaries		NW Rehab, LLC	100.00%	274	274	27
28	V	21	Clerical & General Office		NW Rehab, LLC	100.00%	20	20	28
29	V	22	Employee Benefits		NW Rehab, LLC	100.00%	191	191	29
30	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	11	11	30
31	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	31	31	31
32	V	26	Insurance		NW Rehab, LLC	100.00%	2	2	32
33	V	32	Interest		NW Rehab, LLC	100.00%	15	15	33
34	V	39	Ancillary Service Centers	1,620	NW Rehab, LLC	100.00%		(1,620)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,307			$ 4,564	$ * (5,743)	39

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

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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 Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Rich # 0050757 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	714,758	3.99	7.99	Distribution	$ 62,030	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	$ 62,030		13

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

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

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and # 0050757 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	$	28,873	$ 251	1
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	28,873	26,158	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788		28,873	62,030	3
4	19	Professional Fees	Resident Days	361,568	13	221,539		28,873	17,691	4
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991		28,873	878	5
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	28,873	124,664	6
7	21	Clercial & Office Supplies	Resident Days	361,568	13	378,981		28,873	30,264	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058		28,873	22,364	8
9	24	Seminars	Resident Days	361,568	13	90,455		28,873	7,223	9
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816		28,873	7,412	10
11	26	Insurance	Resident Days	361,568	13	26,711		28,873	2,133	11
12	30	Depreciation	Resident Days	361,568	13	20,874		28,873	1,667	12
13	33	Real Estate Taxes	Resident Days	361,568	13	269		28,873	21	13
14	34	Building Rent	Resident Days	361,568	13	95,732		28,873	7,645	14
15	34	Rental - Storage Unit	Resident Days	361,568	13	3,073		28,873	245	15
16	35	Equipment Rental	Resident Days	361,568	13	9,286		28,873	742	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		$ 311,388	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and # 0050757 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						$	$		$	1
2	30	Depreciation	Revenue	70,485	7	17,596		7,921	1,977	2
3	34	Building Rent	Revenue	70,485	7	2,079		7,921	234	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	$		$ 2,211	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and # 0050757 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: NW Rehab, LLC
Street Address:
City / State / Zip Code:
Phone Number: (
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing & Med	Revenue	2,581,783	19	$ 73	$	1,710	$	1
2	10a	Therapy	Revenue	2,581,783	19	1,610,942	1,610,942	1,710	1,067	2
3	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	1,710	274	3
4	20	Dues & Subscriptions	Revenue	2,581,783	19	136		1,710		4
5										5
6	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456		1,710	20	6
7	22	Employee Benefits	Revenue	2,581,783	19	288,251		1,710	191	7
8	24	Travel & Seminar	Revenue	2,581,783	19	16,377		1,710	11	8
9	25	Other Admin Transp	Revenue	2,581,783	19	46,860		1,710	31	9
10	26	Insurance - Prop Liab, Malprac	Revenue	2,581,783	19	3,500		1,710	2	10
11	32	Interest	Revenue	2,581,783	19	22,721		1,710	15	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					$ 2,433,380	$ 2,025,006		$ 1,611	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richl # 0050757 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	383,101	6
7												7
8	Related Party Allocation										15	8
9	TOTAL Facility Related						$	$			$ 383,116	9
	B. Non-Facility Related*											
10	Interest Income Offset											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 383,116	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 Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 **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.**	$ 63,786	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.)		$ 50,394	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,392)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,178	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.		$ 62,786	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	59,279	8
	2013	62,472	9
	2014	66,338	10
	2015	69,295	11
	2016	50,394	12

62,786	Line 7, Real Estate portion of Lease payment
21	Bridgemark Healthcare Allocation
62,807	Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and R COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0050757

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.	06-27-450-002	Plat/Block/Lot PT SW SE SE	$ 50,393.88	$ 50,393.88
2.		Unplatted 55	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,393.88	$ 50,393.88

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 Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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	20,000 Watt Generator			2010	8,067		5			8,067	9
10	Upgrade Existing Fire Alarm System			2010	16,191	1,619	10	1,619		12,683	10
11	Fire Alarm Panel & Fire Doors			2011	20,209	1,954	10	1,954		12,816	11
12	A/C Sytem Improvements & New A/C Units			2011	9,134	159	15	159		7,744	12
13	Signs			2012	7,427	743	10	743		3,837	13
14	AC Unit Replacement			2013	5,592	559	10	559		2,703	14
15	Toilets, Tubs, Lavatories, BR Fixtures, ARCH Unit			2013	5,259	263	20	263		1,315	15
16	Kitchen Cabinets, Countertops - ARCH Unit			2013	5,523	368	15	368		1,841	16
17	Door ARCH Unit			2013	10,320	688	15	688		3,440	17
18	Call System ARCH Unit			2013	1,026	103	10	103		513	18
19	Flooring ARCH Unit			2013	10,671	2,134	5	2,134		6,475	19
20	Curtains, Drapes, Blinds - ARCH Unit			2013	2,578	516	5	516		2,578	20
21	Pendent Sprinklers			2013	1,290	86	15	86		430	21
22	GE Door Alarm Keypad - ARCH Unit			2013	1,074	107	10	107		537	22
23	Dining/Bathroom Flooring - ARCH Unit			2013	4,255	426	10	426		2,128	23
24	HTG & AC for Shower Room - ARCH Unit			2013	682	136	10	136		682	24
25	Fireplace			2013	1,499	150	5	150		725	25
26	Tear out old walls & replace - ARCH Unit			2013	157,405	7,870	10	7,870		39,351	26
27	4 Frigidaire Heat/Cool Units			2014	2,503	250	10	250		939	27
28	Replace water heater			2014	1,436	144	10	144		467	28
29	Schrey System			2014	1,792	179	10	179		582	29
30	CTS ran phone & data cable			2014	878	88	10	88		285	30
31	Redo all kitchen plumbing			2014	7,222	722	10	722		2,468	31
32	Frigidaire heat/cool units			2014	1,259	252	5	252		860	32
33	Whisper Grove Hall - prep/paint/floor			2015	8,331	833	10	833		1,944	33
34	Read's Inc. - AC/Heat Unit			2015	5,806	1,161	5	1,161		3,387	34
35	Harwood Flooring & Paint - A Hall			2016	3,581	358	10	358		388	35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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			$	$		$	$	$	37
38	Related Party Allocation - Bridgemark Healthcare, LLC								38
39	New Office Build Out	2011	10,846		20	574	574	3,706	39
40	Conference Rm Chair Rail & Paint	2012	123		5	16	16	123	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)		$ 311,979	$ 21,868		$ 22,458	$ 590	$ 123,014	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 Olney, L.L.C. d/b/a Richland Ca# 0050757 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	$ 150,171	$ 12,266	$ 15,320	$ 3,054	3-15 Yrs	$ 69,374	71
72	Current Year Purchases	10,364	608	608		3-15 Yrs	608	72
73	Fully Depreciated Assets	35,959					35,959	73
74								74
75	TOTALS	$ 196,494	$ 12,874	$ 15,928	$ 3,054		$ 105,941	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Ford E-450	2010	$ 3,407	$	$	$	4	$ 3,407	76
77	Related Party Allocation - Bridgemark			1,061				4	1,061	77
78										78
79										79
80	TOTALS			$ 4,468	$	$	$		$ 4,468	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)	$ 512,941	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,742	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,386	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,644	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 233,423	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and # 0050757 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: CR Aviv, LLC.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [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		$ 738,745			3
4	Additions							4
5	Related Party Allocation				8,124			5
6	Storage Rental				2,361			6
7	TOTAL		118		$ 749,230 **			7

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 865 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 Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				600		600	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				122,036		122,036	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					35,194		35,194	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				688,882			688,882	13
14	TOTAL			$		$ 688,882	$ 157,830		$ 846,712	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 Olney, L.L.C. d/b/a Richland Care and # 0050757 **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	$ 2,676	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 97,796)	983,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,421		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	130,494		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,127,704	$	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	294,258		15
16	Equipment, at Historical Cost	156,613		16
17	Accumulated Depreciation (book methods)	(197,958)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	76,652		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 329,565	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,457,269	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,503,944	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,484		30
31	Accrued Taxes Payable (excluding real estate taxes)	993		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,178		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	4,914,842		36
37	Accrued Provider Assessments	25,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,599,941	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,599,941	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,142,672)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,457,269	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 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**	$ (4,732,088)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,732,088)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(410,584)	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)**	$ (410,584)	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)**	$ (5,142,672)	24	*

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland C # 0050757 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,103,642	1
2	Discounts and Allowances for all Levels	(85,039)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,018,603	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,190	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 216,190	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	459	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)**	$ 459	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	8,613	28
28a	Medical Records Income	195	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,808	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,244,060	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	795,753	31
32	Health Care	1,475,780	32
33	General Administration	1,091,701	33
	B. Capital Expense		
34	Ownership	1,230,545	34
	C. Ancillary Expense		
35	Special Cost Centers	846,112	35
36	Provider Participation Fee	214,753	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,654,644	40
41	**Income before Income Taxes (line 30 minus line 40)****	(410,584)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (410,584)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,307,322	44
45	Private Pay - Net Inpatient Revenue	368,498	45
46	Medicare - Net Inpatient Revenue	2,197,222	46
47	Other-(specify) Hospice	10,622	47
48	Other-(specify) Insurance	134,939	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,018,603	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 Olney, L.L.C. d/b/a Richland Care and I # 0050757 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	1,934	2,082	$ 70,166	$ 33.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,437	11,107	285,045	25.66	3
4	Licensed Practical Nurses	13,983	14,999	332,370	22.16	4
5	CNAs & Orderlies	44,065	46,492	529,313	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	282	317	5,175	16.32	8
9	Activity Director					9
10	Activity Assistants	1,780	1,919	24,782	12.91	10
11	Social Service Workers	1,850	2,048	35,453	17.31	11
12	Dietician					12
13	Food Service Supervisor	2,077	2,143	37,004	17.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,956	13,756	135,366	9.84	15
16	Dishwashers					16
17	Maintenance Workers	142	161	3,014	18.72	17
18	Housekeepers	11,945	12,880	149,625	11.62	18
19	Laundry	4,652	5,001	49,895	9.98	19
20	Administrator	1,465	1,644	61,105	37.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,967	2,161	41,726	19.31	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	911	944	11,976	12.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,446	117,654	$ 1,772,015 *	$ 15.06	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		$ 7,550	1,3	35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		3,444	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,527	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		4,464	11,3	44
45	Social Service Consultant		2,580	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 33,565		49

C. CONTRACT NURSES

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

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Car # 0050757 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Brashear	Administrator	0	$ 61,105
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,105

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 267,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 267,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting Services	$ 1,093
Paycom Payroll, LLC	Payroll Processing	11,497
Personnel Planner, Inc.	Unemployment Consulting	1,255
Steven B. Pearlman & Associate	Real Estate Tax Appeal	5,531
Ashman and Stein	Legal Fees	513
Resident Receivables, LLC	Collections -- eliminated	507
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,396

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,231
Unemployment Compensation Insurance	37,844
FICA Taxes	132,992
Employee Health Insurance	19,651
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,321
Employee Benefits	
Other Employee Benefits	1,796
Related Party Allocations - Bridgemark	22,364
Related Party Allocations - NW Rehab	191
TOTAL (agree to Schedule V, line 22, col.8)	$ 266,390

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	7,633
Health Care Worker Background Check	2,953
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	7,029
Late Fees	146,353
Miscellaneous Licenses & Fees	375
Advertising	43,538
Related Party Allocation - Bridgemark	878
Less: Public Relations Expense	( )
Non-allowable advertising	(43,538)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 167,211

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	90
Seminar Expense	1,278
Related Party Allocation - Bridgemark	7,223
Related Party Allocation - NW Rehab	11
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,602

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Helia Healthcare of Olney, L.L.C. d/b/a Richland Care and Rehab # 0050757 **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. $ **16,320** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **214,753**
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. $ **459**

(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? **Yes**
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. $ **No**

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

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

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

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

	Description	
16A	Nursing Equipment	123
16B	Related Party Allocation - Bridgemark Healthcare	742
		865

Helia Healthcare of Olney
Attachment to Schedule XVII E
Other Revenue
12/31/2017

	Description	
16A	Medical Records	195
16B	Miscellaneous Income	8,613
		8,808