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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0049775

Facility Name: Helia Healthcare of Benton

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

County: Franklin

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Jason Mills
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,629	5,390	5,190	22,209	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,629	5,390	5,190	22,209	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.31%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/08

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 4,379

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: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	89,377	12,976	124,298	226,651		226,651		226,651			1
2	Food Purchase		154,574		154,574		154,574	(186)	154,388			2
3	Housekeeping	139,219	25,734	1,397	166,350		166,350		166,350			3
4	Laundry	3,526	5,418	93,100	102,044		102,044	(15,811)	86,233			4
5	Heat and Other Utilities			108,101	108,101		108,101	4,990	113,091			5
6	Maintenance	167	27,549	27,014	54,730		54,730	57,343	112,073			6
7	Other (specify):*											7
8	TOTAL General Services	232,289	226,251	353,910	812,450		812,450	46,336	858,786			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,173,566	85,515	31,230	1,290,311		1,290,311	15,655	1,305,966			10
10a	Therapy		890		890		890	1,172	2,062			10a
11	Activities	42,702	8,126	3,154	53,982		53,982	(205)	53,777			11
12	Social Services	41,243	147	1,705	43,095		43,095		43,095			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,257,511	94,678	54,089	1,406,278		1,406,278	16,622	1,422,900			16
	C. General Administration											
17	Administrative	84,815		241,400	326,215		326,215	(223,672)	102,543			17
18	Directors Fees											18
19	Professional Services			15,292	15,292		15,292	14,605	29,897			19
20	Dues, Fees, Subscriptions & Promotions			77,416	77,416		77,416	(58,696)	18,720			20
21	Clerical & General Office Expenses	120,002	21,425	105,647	247,074		247,074	120,954	368,028			21
22	Employee Benefits & Payroll Taxes			222,100	222,100		222,100	35,962	258,062			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,283	3,283		3,283	4,376	7,659			24
25	Other Admin. Staff Transportation			8,827	8,827		8,827	23,224	32,051			25
26	Insurance-Prop.Liab.Malpractice			95,032	95,032		95,032	1,323	96,355			26
27	Other (specify):*											27
28	TOTAL General Administration	204,817	21,425	768,997	995,239		995,239	(81,924)	913,315			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,694,617	342,354	1,176,996	3,213,967		3,213,967	(18,966)	3,195,001			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton #0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			24,441	24,441		24,441	13,239	37,680			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,132	39,132		39,132	(8,923)	30,209			32
33	Real Estate Taxes			21,000	21,000		21,000	792	21,792			33
34	Rent-Facility & Grounds			305,695	305,695		305,695	(293,460)	12,235			34
35	Rent-Equipment & Vehicles			16,998	16,998		16,998	703	17,701			35
36	Other (specify):*											36
37	**TOTAL Ownership**			407,266	407,266		407,266	(287,649)	119,617			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		166,170	622,916	789,086		789,086	(1,703)	787,383			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,521	158,521		158,521		158,521			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		166,170	781,437	947,607		947,607	(1,703)	945,904			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,694,617	508,524	2,365,699	4,568,840		4,568,840	(308,318)	4,260,522			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(205)	11		4
5	Telephone, TV & Radio in Resident Rooms	(6,901)	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	(8,941)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	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	(200)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,379)	21		19
20	Contributions	(354)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(51,066)	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	(8,466)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,698)		$	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)	(227,620)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (227,620)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (308,318)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Benton

ID# 0049775

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	$ (8,710)	20	1
2	To Eliminate Lobbying/PAC Dues	(1,746)	20	2
3	To Record IDPH Fees Paid in Prior Year	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**	(8,466)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(186)	0	0	0	0	0	0	0	0	0	0	(186)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(15,811)	0	0	0	0	0	0	0	0	(15,811)	4
5	Heat and Other Utilities	(6,901)	461	11,430	0	0	0	0	0	0	0	0	4,990	5
6	Maintenance	0	0	57,343	0	0	0	0	0	0	0	0	57,343	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,087)	461	52,962	0	0	0	0	0	0	0	0	46,336	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	15,655	0	0	0	0	0	0	0	0	0	15,655	10
10a	Therapy	0	0	0	1,172	0	0	0	0	0	0	0	1,172	10a
11	Activities	(205)	0	0	0	0	0	0	0	0	0	0	(205)	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**	(205)	15,655	0	1,172	0	0	0	0	0	0	0	16,622	16
	C. General Administration													
17	Administrative	0	(223,902)	0	230	0	0	0	0	0	0	0	(223,672)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,521	1,084	0	0	0	0	0	0	0	0	14,605	19
20	Fees, Subscriptions & Promotions	(59,732)	1,036	0	0	0	0	0	0	0	0	0	(58,696)	20
21	Clerical & General Office Expenses	(4,733)	122,329	3,339	19	0	0	0	0	0	0	0	120,954	21
22	Employee Benefits & Payroll Taxes	0	14,900	20,869	193	0	0	0	0	0	0	0	35,962	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,364	0	12	0	0	0	0	0	0	0	4,376	24
25	Other Admin. Staff Transportation	0	5,056	18,144	24	0	0	0	0	0	0	0	23,224	25
26	Insurance-Prop.Liab.Malpractice	0	893	430	0	0	0	0	0	0	0	0	1,323	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(64,465)	(61,803)	43,866	478	0	0	0	0	0	0	0	(81,924)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,757)	(45,687)	96,828	1,650	0	0	0	0	0	0	0	(18,966)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	1,253	11,986	0	0	0	0	0	0	0	0	13,239	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,941)	0	0	18	0	0	0	0	0	0	0	(8,923)	32
33	Real Estate Taxes	0	44	748	0	0	0	0	0	0	0	0	792	33
34	Rent-Facility & Grounds	0	6,426	(299,886)	0	0	0	0	0	0	0	0	(293,460)	34
35	Rent-Equipment & Vehicles	0	0	703	0	0	0	0	0	0	0	0	703	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,941)	7,723	(286,449)	18	0	0	0	0	0	0	0	(287,649)	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	(1,703)	0	0	0	0	0	0	0	(1,703)	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	(1,703)	0	0	0	0	0	0	0	(1,703)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(80,698)	(37,964)	(189,621)	(35)	0	0	0	0	0	0	0	(308,318)	45

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			
		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%	$ 461	$ 461	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	15,655	15,655	2
3	V	17	Management Fees	241,400	Bridgemark Healthcare, LLC	100.00%	17,498	(223,902)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	13,521	13,521	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,036	1,036	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	122,329	122,329	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	14,900	14,900	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,364	4,364	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,056	5,056	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	893	893	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,253	1,253	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	44	44	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	6,426	6,426	13
14	Total			$ 241,400			$ 203,436	$ * (37,964)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	$ 587	$ 587	15
16	V								16
17	V	30	Depreciation		BM Properties I - Benton	100.00%	6,670	6,670	17
18	V	33	Real Estate Taxes	21,000	BM Properties I - Benton	100.00%	20,225	(775)	18
19	V	34	Rent - Facility & Grounds	302,950	BM Properties I - Benton	100.00%		(302,950)	19
20	V								20
21	V								21
22	V	4	Laundry	93,100	Helia Healthcare Services	100.00%	77,289	(15,811)	22
23	V	5	Utilities		Helia Healthcare Services	100.00%	11,430	11,430	23
24	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	60,343	57,343	24
25	V	19	Professional Services		Helia Healthcare Services	100.00%	1,084	1,084	25
26	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	3,339	3,339	26
27	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	20,869	20,869	27
28	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	18,144	18,144	28
29	V	26	Insurance		Helia Healthcare Services	100.00%	430	430	29
30	V	30	Depreciation		Helia Healthcare Services	100.00%	5,316	5,316	30
31	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,523	1,523	31
32	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	3,064	3,064	32
33	V	35	Rent - Vehicle		Helia Healthcare Services	100.00%	116	116	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 420,050			$ 230,429	$ * (189,621)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	10	Nursing & Med	$	NW Rehab, LLC	100.00%	$	$	15
16	V	10a	Therapy		NW Rehab, LLC	100.00%	1,172	1,172	16
17	V	17	Admin Salaries		NW Rehab, LLC	100.00%	230	230	17
18	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%			18
19	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	19	19	19
20	V	22	Employee Benefits		NW Rehab, LLC	100.00%	193	193	20
21	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	12	12	21
22	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	24	24	22
23	V	32	Interest		NW Rehab, LLC	100.00%	18	18	23
24	V	39	Ancillary Services	1,703	NW Rehab, LLC	100.00%		(1,703)	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			$ 1,703			$ 1,668	$ * (35)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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								1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Jerseyville	Jerseyville, IL				5
6			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				6
7			Helia Healthcare of Effingham	Effingham, IL				7
8			Helia Healthcare of Salem	Salem, IL				8
9			Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO				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 Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	282,502	2.92	5.83	Distribution	$ 17,498	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	$ 17,498		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 Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	380,780	15	$ 7,897	$	22,209	$ 461	1
2	10	Nursing & Medical Supplies	Resident Days	380,780	15	268,418	268,418	22,209	15,655	2
3	17	Owner's Compensation	Resident Days	380,780	15	300,000		22,209	17,498	3
4	19	Professional Fees	Resident Days	380,780	15	231,817		22,209	13,521	4
5	20	Dues, Subscriptions	Resident Days	380,780	15	17,755		22,209	1,036	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	22,209	104,998	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		22,209	17,331	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	380,780	15	255,471		22,209	14,900	8
9	24	Travel & Seminar	Resident Days	380,780	15	74,815		22,209	4,364	9
10	25	Admin Staff Travel	Resident Days	380,780	15	86,690		22,209	5,056	10
11	26	Insurance	Resident Days	380,780	15	15,316		22,209	893	11
12	30	Depreciation	Resident Days	380,780	15	21,481		22,209	1,253	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		22,209	44	13
14	34	Building Rent	Resident Days	380,780	15	102,060		22,209	5,953	14
15	34	Rental - Storage Unit	Resident Days	380,780	15	8,118		22,209	473	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		22,209	587	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,498,033	$ 2,068,642		$ 204,023	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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	2,717,752	19	$ 792	$	1,703	$	1
2	10a	Therapy	Revenue	2,717,752	19	1,870,778	1,870,778	1,703	1,172	2
3	17	Admin Salaries	Revenue	2,717,752	19	366,622	366,622	1,703	230	3
4	20	Dues & Subscriptions	Revenue	2,717,752	19	41		1,703		4
5	21	Clerical & Office Supplies	Revenue	2,717,752	19	30,294		1,703	19	5
6	22	Employee Benefits	Revenue	2,717,752	19	308,794		1,703	193	6
7	24	Travel & Seminar	Revenue	2,717,752	19	19,790		1,703	12	7
8	25	Other Admin Transp	Revenue	2,717,752	19	37,856		1,703	24	8
9	32	Interest	Revenue	2,717,752	19	28,025		1,703	18	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					$ 2,662,992	$ 2,237,400		$ 1,668	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	250,260	3	$ 201,274	$ 173,530	96,100	$ 77,289	1
2	5	Utilities	Revenue	250,260	3	29,766		96,100	11,430	2
3	6	Maintenance	Revenue	250,260	3	157,143	147,458	96,100	60,343	3
4	19	Professional Services	Revenue	250,260	3	2,823		96,100	1,084	4
5	21	Clerical & Office Supplies	Revenue	250,260	3	8,696		96,100	3,339	5
6	22	Payroll Taxes & Emp Benefits	Revenue	250,260	3	54,347		96,100	20,869	6
7	25	Other Admin Transportation	Revenue	250,260	3	47,251		96,100	18,144	7
8	26	Insurance	Revenue	250,260	3	1,119		96,100	430	8
9	30	Depreciation	Revenue	250,260	3	13,843		96,100	5,316	9
10	33	Real Estate Taxes	Revenue	250,260	3	3,966		96,100	1,523	10
11	34	Rent - Facility	Revenue	250,260	3	7,980		96,100	3,064	11
12	35	Rent - Vehicle	Revenue	250,260	3	303		96,100	116	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					$ 528,511	$ 320,988		$ 202,947	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding, LLC		X	Line of Credit		10/22/09				Variable	39,132	6
7												7
8	Related Party Allocation										18	8
9	TOTAL Facility Related						$	$			$ 39,150	9
	B. Non-Facility Related*											
10	Interest Income Offset										(8,941)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,941)	14
15	TOTALS (line 9+line14)						$	$			$ 30,209	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 23,423	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.)		$ 23,423	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 21,000	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.		$ 21,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	18,765	8
2014	19,031	9
2015	19,092	10
2016	19,879	11
2017	20,225	12

21,000 Line 7
792 Related Pary Adjustments
21,792 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-07-455-802	Sec 07 TWP 06 RNG 03 E 1.68	$ 20,225.00	$ 20,225.00
2.		AC SW COR 1/4 SW 1.4	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,225.00	$ 20,225.00

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation - Helia Healthcare			$ 1,924	1
2					2
3	TOTALS			$ 1,924	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 51,278	$	25	$ 2,564	$ 2,564	$ 11,658	4
5	83		2008		134,098		30	4,470	4,470	46,562	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		807	9
10	Exterior Sign			2009	5,265	527	10	527		5,177	10
11	Wallcovering for hallways & entranceway, door, shower remodel			2009	11,252	750	15	750		7,001	11
12	Carpet			2009	1,170		5			1,170	12
13	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		1,576	13
14	New Pipes, Install Eye Wash			2010	2,215	88	25	88		761	14
15	AC, Fans, Dehumidifier			2010	1,609	161	10	161		1,367	15
16	Outside Singe Door & Frame			2010	4,168	278	15	278		2,292	16
17	Shower Room - Tile, shower heards, electrical work, fixtures, paint			2011	3,860	257	15	257		1,949	17
18	Dinette/Common area remodel - doors, windows, countertops, cabinetry										18
19	(cont.) Flooring, electrical, plywood, paint			2011	13,693	913	15	913		6,925	19
20	Back-Up Generator			2011	12,864	643	20	643		4,717	20
21	Sprinkler System			2012	97,800	3,912	25	3,912		27,384	21
22	Fire Doors			2012	9,942	663	15	663		4,529	22
23	Oxygen Shed			2012	1,941	194	10	194		1,246	23
24	AC Equipment North Hallway			2014	1,896	190	10	190		853	24
25	Painting 1 Room, 1/2 North Hall			2014	250	50	5	50		208	25
26	Therapy Remodel - flooring, painting, & lighting			2015	4,045	270	15	270		989	26
27	Vinyl Sliding Door & Installation			2015	5,325	355	15	355		1,213	27
28	Flooring in North Hall rooms and hallway			2015	7,282	485	15	485		1,618	28
29	Lighting, Drywall, Paint and Flooring in Back Hallway			2017	4,690	313	15	313		469	29
30	New Countertop and Paint for Nurse Station in South Hall			2017	2,922	195	15	195		244	30
31	Lights, Flooring, Paint, Door Handles, and new Cabinets for										31
32	Therapy Room			2017	16,563	1,104	15	1,104		1,563	32
33	New Pipes and Plumbing for North Hall Shower			2017	2,077	139	15	139		197	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation - Bridgemark Healthcare LLC		$	$		$	$	$	37
38	New Office Build Out	2011	7,921		20	419	419	3,126	38
39	Conference Room Chair Rail & Paint	2012	90		5			90	39
40	AC Unit in Server Room	2018	614		20	15	15	15	40
41									41
42									42
43	Related Party Allocation - Helia Healthcare								43
44	Water & Sewer Pipe Instalation	2006	730		20	36	36	453	44
45	Plumbing & Heating Installation	2006	874		20	44	44	542	45
46	A/C Unit - 4 Ton	2007	2,104		10			2,104	46
47	400 Gal. Water Storage Tank	2016	5,938		10	594	594	1,435	47
48	AC Compressor at Martin's Catering Building	2018	960		15	32	32	32	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)		$ 419,213	$ 11,738		$ 19,912	$ 8,174	$ 140,272	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 158,740	$ 10,629	$ 15,520	$ 4,891	3-15	$ 96,819	71
72	Current Year Purchases	24,493	2,074	2,248	174	3-15	2,248	72
73	Fully Depreciated Assets	45,407					45,407	73
74								74
75	TOTALS	$ 228,640	$ 12,703	$ 17,768	$ 5,065		$ 144,474	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2011	$ 28,821	$	$	$		$ 28,821	76
77	Related Party Allocation - Bridgemark		2005	775					775	77
78	Related Party Allocation - Helia Healthcare		2006	2,577					2,577	78
79										79
80	TOTALS			$ 32,173	$	$	$		$ 32,173	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)	$ 681,950	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,441	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,680	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,239	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 316,919	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 Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				2,745			5
6	Related Party Allocation				9,490			6
7	TOTAL				$ 12,235 **			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 ☒ 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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,701 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				890		890	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				143,406		143,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enternals	39, 2					22,764		22,764	12
13	Other (specify): X-Ray, Labs, Therapy	39, 8				621,213			621,213	13
14	TOTAL			$		$ 621,213	$ 167,060		$ 788,273	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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 7,232	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	675,540		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,456,300		8
9	Other(specify): Deposits	1,426		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,140,498	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	214,607		15
16	Equipment, at Historical Cost	181,231		16
17	Accumulated Depreciation (book methods)	(183,116)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	21,000		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 233,722	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,374,220	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,967,249	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,641		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,637		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	9,299		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,071,826	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	123,729		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 123,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,195,555	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,178,665	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,374,220	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,229,339	1
2	Restatements (describe):		2
3	**Prior Year Adjustments made after cost report submitted**	(276,968)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,952,371	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	226,294	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)**	$ 226,294	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,178,665	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,655,704	1
2	Discounts and Allowances for all Levels	(77,609)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,578,095	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	191,735	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 191,735	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	205	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)**	$ 205	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,941	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,941	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	16,158	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,158	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,795,134	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	812,450	31
32	Health Care	1,406,278	32
33	General Administration	995,239	33
	B. Capital Expense		
34	Ownership	407,266	34
	C. Ancillary Expense		
35	Special Cost Centers	789,086	35
36	Provider Participation Fee	158,521	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,568,840	40
41	**Income before Income Taxes (line 30 minus line 40)****	226,294	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 226,294	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,441,221	44
45	Private Pay - Net Inpatient Revenue	765,906	45
46	Medicare - Net Inpatient Revenue	2,118,766	46
47	Other-(specify) Insurance	239,166	47
48	Other-(specify) Hospice	13,036	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,578,095	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,715	1,897	$ 66,197	$ 34.90	1
2	Assistant Director of Nursing	688	688	13,879	20.17	2
3	Registered Nurses	6,629	7,150	201,986	28.25	3
4	Licensed Practical Nurses	14,441	15,664	371,783	23.73	4
5	CNAs & Orderlies	42,040	44,604	513,540	11.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,430	3,591	42,702	11.89	10
11	Social Service Workers	2,109	2,239	41,243	18.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,936	7,432	89,377	12.03	15
16	Dishwashers					16
17	Maintenance Workers	15	15	167	11.13	17
18	Housekeepers	10,691	11,540	139,219	12.06	18
19	Laundry	398	398	3,526	8.86	19
20	Administrator	1,829	2,080	84,815	40.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,138	2,246	54,330	24.19	23
24	Clerical	2,962	3,177	65,672	20.67	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	243	665	6,181	9.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,264	103,386	$ 1,694,617 *	$ 16.39	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		18,000	9, 3	36
37	Medical Records Consultant		1,834	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,172	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,154	11, 3	44
45	Social Service Consultant		1,705	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,865		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Loretta Ellis	Administrator	0	$ 84,815
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,815

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fee	$ 241,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 241,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting	$ 2,175
Personnel Planners, Inc	Unemployment Consulting	1,893
Paycom Payroll. LLC	Payroll Processing	11,224
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 15,292

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,377
Unemployment Compensation Insurance	25,909
FICA Taxes	128,680
Employee Health Insurance	35,614
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,607
Employee Benefits	3,386
Other Employee Insurance	(473)
Related Party Allocation - Bridgemark	14,900
Related Party Allocation - Helia Healthcare	20,869
Related Party Allocation - NW Rehab	193
TOTAL (agree to Schedule V, line 22, col.8)	$ 258,062

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	5,158
Health Care Worker Background Check	2,939
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	7,488
Late Fees	
Miscellaneous Licenses & Fees	109
Advertising	51,066
Related Party Allocation - Bridgemark	1,036
Less: Public Relations Expense	( )
Non-allowable advertising	(51,066)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,720

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,042
Seminar Expense	2,241
Related Party Allocation - Bridgemark	4,364
Related Party Allocation - NW Rehab	12
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,659

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,732**

(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. $ **12,757** 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. $ **158,521**
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. $ **205**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2018

	Description	
16A	Nursing Equipment	11,217
16B	Copier Lease	3,300
16C	Computers & Software	2,123
16D	Postage Machine	358
16E	Related Party Allocation - Bridgemark Healthcare	587
16F	Related Party Allocation - Helia Healthcare	116
		17,701