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: 0048181

Facility Name: Helia Healthcare of Champaign

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

County: Champaign

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 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 Champaign # 0048181 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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,488	3,969	4,741	20,198	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,488	3,969	4,741	20,198	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.90%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/06

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 2,374

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 Champaign # 0048181 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	177,715	16,432	19,114	213,261		213,261		213,261			1
2	Food Purchase		150,227		150,227		150,227	(146)	150,081			2
3	Housekeeping	93,021	23,514	1,345	117,880		117,880		117,880			3
4	Laundry	25,682	8,016	2,362	36,060		36,060		36,060			4
5	Heat and Other Utilities			99,737	99,737		99,737	(7,992)	91,745			5
6	Maintenance	41,976	12,310	48,956	103,242		103,242		103,242			6
7	Other (specify):*											7
8	TOTAL General Services	338,394	210,499	171,514	720,407		720,407	(8,138)	712,269			8
	B. Health Care and Programs											
9	Medical Director			32,000	32,000		32,000		32,000			9
10	Nursing and Medical Records	1,283,438	109,140	37,582	1,430,160		1,430,160	13,923	1,444,083			10
10a	Therapy		62		62		62	2,659	2,721			10a
11	Activities	33,580	4,063	3,437	41,080		41,080		41,080			11
12	Social Services	46,436	11	2,187	48,634		48,634		48,634			12
13	CNA Training											13
14	Program Transportation			11,622	11,622		11,622		11,622			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,363,454	113,276	86,828	1,563,558		1,563,558	16,582	1,580,140			16
	C. General Administration											
17	Administrative	160,057		196,300	356,357		356,357	(179,866)	176,491			17
18	Directors Fees											18
19	Professional Services			33,886	33,886		33,886	12,296	46,182			19
20	Dues, Fees, Subscriptions & Promotions			60,958	60,958		60,958	(42,433)	18,525			20
21	Clerical & General Office Expenses	64,563	12,647	264,395	341,605		341,605	1,166	342,771			21
22	Employee Benefits & Payroll Taxes			251,049	251,049		251,049	13,990	265,039			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,635	3,635		3,635	3,996	7,631			24
25	Other Admin. Staff Transportation			10,695	10,695		10,695	4,652	15,347			25
26	Insurance-Prop.Liab.Malpractice			85,119	85,119		85,119	812	85,931			26
27	Other (specify):*											27
28	TOTAL General Administration	224,620	12,647	906,037	1,143,304		1,143,304	(185,387)	957,917			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,926,468	336,422	1,164,379	3,427,269		3,427,269	(176,943)	3,250,326			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Champaign #0048181 Report Period Beginning: 01/01/18 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			57,568	57,568		57,568	1,139	58,707			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,611	40,611		40,611	(10,344)	30,267			32
33	Real Estate Taxes			40,506	40,506		40,506	40	40,546			33
34	Rent-Facility & Grounds			127,194	127,194		127,194	5,845	133,039			34
35	Rent-Equipment & Vehicles			67,666	67,666		67,666	534	68,200			35
36	Other (specify):*											36
37	**TOTAL Ownership**			333,545	333,545		333,545	(2,786)	330,759			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		214,287	555,077	769,364		769,364	(3,863)	765,501			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,646	176,646		176,646		176,646			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		214,287	731,723	946,010		946,010	(3,863)	942,147			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,926,468	550,709	2,229,647	4,706,824		4,706,824	(183,592)	4,523,232			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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				4
5	Telephone, TV & Radio in Resident Rooms	(8,411)	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	(10,384)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(146)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(747)	20		17
18	Fines and Penalties	(104,177)	21		18
19	Entertainment	(5,898)	21		19
20	Contributions	(55)	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	(34,130)	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	(8,814)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (172,762)		$	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)	(10,830)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,830)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (183,592)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Champaign

ID# 0048181

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To eliminate gifts & flowers	$ (2,017)	20	1
2	To offset medical records income	(316)	10	2
3	To eliminate lobbying & PAC dues	(2,482)	20	3
4	To eliminate excess IDPH license fees	(3,999)	20	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**	(8,814)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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	(146)	0	0	0	0	0	0	0	0	0	0	(146)	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	(8,411)	419	0	0	0	0	0	0	0	0	0	(7,992)	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**	(8,557)	419	0	0	0	0	0	0	0	0	0	(8,138)	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	(316)	14,238	1	0	0	0	0	0	0	0	0	13,923	10
10a	Therapy	0	0	2,659	0	0	0	0	0	0	0	0	2,659	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(316)	14,238	2,660	0	0	0	0	0	0	0	0	16,582	16
	C. General Administration													
17	Administrative	0	(180,387)	521	0	0	0	0	0	0	0	0	(179,866)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,296	0	0	0	0	0	0	0	0	0	12,296	19
20	Fees, Subscriptions & Promotions	(43,375)	942	0	0	0	0	0	0	0	0	0	(42,433)	20
21	Clerical & General Office Expenses	(110,130)	111,253	43	0	0	0	0	0	0	0	0	1,166	21
22	Employee Benefits & Payroll Taxes	0	13,551	439	0	0	0	0	0	0	0	0	13,990	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,968	28	0	0	0	0	0	0	0	0	3,996	24
25	Other Admin. Staff Transportation	0	4,598	54	0	0	0	0	0	0	0	0	4,652	25
26	Insurance-Prop.Liab.Malpractice	0	812	0	0	0	0	0	0	0	0	0	812	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(153,505)	(32,967)	1,085	0	0	0	0	0	0	0	0	(185,387)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(162,378)	(18,310)	3,745	0	0	0	0	0	0	0	0	(176,943)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 **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	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	1,139	0	0	0	0	0	0	0	0	0	1,139	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,384)	0	40	0	0	0	0	0	0	0	0	(10,344)	32
33	Real Estate Taxes	0	40	0	0	0	0	0	0	0	0	0	40	33
34	Rent-Facility & Grounds	0	5,845	0	0	0	0	0	0	0	0	0	5,845	34
35	Rent-Equipment & Vehicles	0	0	534	0	0	0	0	0	0	0	0	534	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,384)	7,024	574	0	0	0	0	0	0	0	0	(2,786)	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	(3,863)	0	0	0	0	0	0	0	0	(3,863)	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	(3,863)	0	0	0	0	0	0	0	0	(3,863)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(172,762)	(11,286)	456	0	0	0	0	0	0	0	0	(183,592)	45

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 Benton	Benton, 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
		Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO			
		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%	$ 419	$ 419	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	14,238	14,238	2
3	V	17	Management Fees	196,300	Bridgemark Healthcare, LLC	100.00%	15,913	(180,387)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	12,296	12,296	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	942	942	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	111,253	111,253	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	13,551	13,551	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,968	3,968	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,598	4,598	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	812	812	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,139	1,139	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	40	40	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	5,845	5,845	13
14	Total			$ 196,300			$ 185,014	$ * (11,286)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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%	$ 534	$ 534	15
16	V								16
17	V								17
18	V	10	Nursing & Med		NW Rehab, LLC	100.00%	1	1	18
19	V	10a	Therapy		NW Rehab, LLC	100.00%	2,659	2,659	19
20	V	17	Admin Salaries		NW Rehab, LLC	100.00%	521	521	20
21	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	43	43	21
22	V	22	Employee Benefits		NW Rehab, LLC	100.00%	439	439	22
23	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	28	28	23
24	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	54	54	24
25	V	32	Interest		NW Rehab, LLC	100.00%	40	40	25
26	V	39	Ancillary Service Ctr.	3,863	NW Rehab, LLC	100.00%		(3,863)	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			$ 3,863			$ 4,319	$ * 456	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Hillsboro	Hillsboro, IL				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6			Helia Healthcare of Effingham	Effingham, IL				6
7			Helia Healthcare of Salem	Salem, IL				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 Champaign # 0048181 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	300,000	2.65	5.30	Distribution	$ 15,913	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	$ 15,913		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 Champaign # 0048181 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	$	20,198	$ 419	1
2	10	Nursing & Medical Supplies	Resident Days	380,780	15	268,418	268,418	20,198	14,238	2
3	17	Owner's Compensation	Resident Days	380,780	15	300,000		20,198	15,913	3
4	19	Professional Fees	Resident Days	380,780	15	231,817		20,198	12,296	4
5	20	Dues, Subscriptions	Resident Days	380,780	15	17,755		20,198	942	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	20,198	95,491	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		20,198	15,762	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	380,780	15	255,471		20,198	13,551	8
9	24	Seminars	Resident Days	380,780	15	74,815		20,198	3,968	9
10	25	Admin Staff Travel	Resident Days	380,780	15	86,690		20,198	4,598	10
11	26	Insurance	Resident Days	380,780	15	15,316		20,198	812	11
12	30	Depreciation	Resident Days	380,780	15	21,481		20,198	1,139	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		20,198	40	13
14	34	Building Rent	Resident Days	380,780	15	102,060		20,198	5,414	14
15	34	Rental - Storage Unit	Resident Days	380,780	15	8,118		20,198	431	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		20,198	534	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		$ 185,548	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 NW Rehab
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing & Med	Revenue	2,717,752	19	$ 792	$	3,863	$ 1	1
2	10a	Therapy	Revenue	2,717,752	19	1,870,778	1,870,778	3,863	2,659	2
3	17	Admin Salaries	Revenue	2,717,752	19	366,622	366,622	3,863	521	3
4	20	Dues & Subscriptions	Revenue	2,717,752	19	41		3,863		4
5	21	Clerical & Office Supplies	Revenue	2,717,752	19	30,294		3,863	43	5
6	22	Employee Benefits	Revenue	2,717,752	19	308,794		3,863	439	6
7	24	Travel & Seminar	Revenue	2,717,752	19	19,790		3,863	28	7
8	25	Other Admin Transp	Revenue	2,717,752	19	37,856		3,863	54	8
9	32	Interest	Revenue	2,717,752	19	28,025		3,863	40	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		$ 3,785	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 I, LLC		X	Line of Credit		10/22/09				Variable	40,611	6
7	Related Party Allocation										40	7
8												8
9	TOTAL Facility Related						$	$			$ 40,651	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(10,384)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,384)	14
15	TOTALS (line 9+line14)						$	$			$ 30,267	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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.**	$ 36,316	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 51,943	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,627	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 24,879	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.		$ 40,506	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	35,956	8
2014	36,282	9
2015	36,595	10
2016	36,316	11
2017	40,506	12

40,506 Line 7, Real Estate Tax Portion of Lease Payments
40 Bridgemark Healthcare Allocation
40,546 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0048181

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 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.	45-20-22-282-005	Long Term Care	$ 40,505.68	$ 40,505.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,505.68	$ 40,505.68

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 Champaign # 0048181 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	Concrete			2006	2,907						10
11	Commercial Floor Covering			2006	5,183						11
12	Wall A/C Units			2006	3,347						12
13	Roofing - D & R Roofing			2007	20,600						13
14	Pipes			2007	8,346						14
15	Life Safety Detectors & Lighted Exit Sign			2007	3,871						15
16	A/C Units			2007	3,039						16
17	Heating & A/C Compressor & A/C Units			2008	7,072						17
18	Roof Top A/C & Roof Repairs			2008	7,347						18
19	Door, Sign & Emergency Back-up Lights			2009	4,174						19
20	Remodel Hall A - New Doors, flooring rails & upgrade nurses station			2009	14,343						20
21	Modern Tile			2010	4,243						21
22	Carpet/ Tile			2010	9,457						22
23	Hot Water Heater			2011	6,504						23
24	Roof Top HVAC Unit			2012	6,700						24
25	Fire Alarm Panel			2013	7,938						25
26											26
27	Installed new phone/internet wiring throughout facility			2014	11,000	733	15	733		3,422	27
28	Lumber for handrails made and installed in the A & B Wings			2014	3,520	235	15	235		1,037	28
29	Install handrails, cabinets, sinks, doors, & carpet - A & B Wings			2014	6,190	413	15	413		1,788	29
30	DS - Emergency Light			2014	223	22	10	22		95	30
31	ARCH (Rehab) Unit - labor, doors, windows, drywall, paint, flooring, fire										31
32	(cont.) alarms, plumbing, architect fees - wings C & D converted			2016	618,036	30,902	20	30,902		64,379	32
33	Replace A/C System			2017	4,250	425	10	425		602	33
34	Install Eye Wash Station			2017	1,600	160	10	160		307	34
35	Paint, Flooring, New Shower, and Labor in Arch Unit			2017	35,575	1,779	20	1,779		3,557	35
36	Door Alarm System with Camaras			2018	5,474	1,003	5	1,003		1,003	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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 - Leasehold Improvements:		$	$		$	$	$	37
38	New Office Build Out	2011	7,204		20	381	381	2,843	38
39	Conference Rm Chair Rail & Paint	2012	82		5			82	39
40	AC Unit in Server Room	2018	559		20	14	14	14	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)		$ 808,784	$ 35,672		$ 36,067	$ 395	$ 79,129	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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	$ 202,486	$ 21,409	$ 22,054	$ 645	3-15	$ 62,890	71
72	Current Year Purchases	9,511	487	586	99	3-15	586	72
73	Fully Depreciated Assets	15,960					15,960	73
74								74
75	TOTALS	$ 227,957	$ 21,896	$ 22,640	$ 744		$ 79,436	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party Allocation - Bridgemark		2005	$ 705	$	$	$	4	$ 705	76
77										77
78										78
79										79
80	TOTALS			$ 705	$	$	$		$ 705	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,037,446	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,568	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 58,707	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,139	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 159,270	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 Champaign # 0048181 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: OMG Champaign Property, 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	5/7/18	$ 114,142			3
4	Additions							4
5	Related Party Allocation - Bridgemark				5,845			5
6	Storage Rental				13,052			6
7	TOTAL		118		$ 133,039 **			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 5/7/18
Ending 4/30/38

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 [X] NO

16. Rental Amount for movable equipment: $ 68,200 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

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

	Description	
16A	Nursing Equipment	57,023
16B	Copier Lease	7,234
16C	Respiratory Equipment	3,409
16D	Related Party Allocation - Bridgemark Healthcare	534
		68,200

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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

Facility Name & ID Number Helia Healthcare of Champaign

STATE OF ILLINOIS
0048181 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				177,794		177,794	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					36,493		36,493	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				551,214			551,214	13
14	TOTAL			$		$ 551,214	$ 214,287		$ 765,501	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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	$ 4,393	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	723,478		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	932		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	5,481		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 734,284	$	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	685,868		15
16	Equipment, at Historical Cost	216,973		16
17	Accumulated Depreciation (book methods)	(146,686)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	24,879		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 781,034	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,515,318	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 895,326	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,016		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,098		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,879		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	175,248		36
37	Accrued Provider Assessment	8,352		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,226,919	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,862		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)**	$ 17,862	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,244,781	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 270,537	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,515,318	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 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**	$ 1,099,326	1
2	Restatements (describe):		2
3	**Prior Year Adjustments after cost report submitted**	(62,826)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,036,500	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(765,963)	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)**	$ (765,963)	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)**	$ 270,537	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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	$ 3,850,432	1
2	Discounts and Allowances for all Levels	(262,148)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,588,284	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	258,119	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 258,119	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,384	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,384	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records	316	28
28a	Miscellaneous and late fee forgiveness	83,758	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 84,074	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,940,861	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	720,407	31
32	Health Care	1,563,558	32
33	General Administration	1,143,304	33
	B. Capital Expense		
34	Ownership	333,545	34
	C. Ancillary Expense		
35	Special Cost Centers	769,364	35
36	Provider Participation Fee	176,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,706,824	40
41	**Income before Income Taxes (line 30 minus line 40)****	(765,963)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (765,963)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,311,008	44
45	Private Pay - Net Inpatient Revenue	633,718	45
46	Medicare - Net Inpatient Revenue	1,134,796	46
47	Other-(specify) Insurance	407,572	47
48	Other-(specify) Hospice	101,190	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,588,284	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

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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	1,622	1,776	$ 65,325	$ 36.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,695	4,066	127,294	31.31	3
4	Licensed Practical Nurses	17,185	17,955	497,985	27.74	4
5	CNAs & Orderlies	38,583	41,243	592,129	14.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	36	39	705	18.08	8
9	Activity Director					9
10	Activity Assistants	1,952	2,109	33,580	15.92	10
11	Social Service Workers	1,900	2,020	46,436	22.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,274	13,786	177,715	12.89	15
16	Dishwashers					16
17	Maintenance Workers	3,374	3,855	41,976	10.89	17
18	Housekeepers	7,614	8,354	93,021	11.13	18
19	Laundry	2,147	2,417	25,682	10.63	19
20	Administrator	2,127	2,168	114,657	52.89	20
21	Assistant Administrator	1,831	2,008	45,400	22.61	21
22	Other Administrative	2,145	1,161	11,609	10.00	22
23	Office Manager	27	242	2,425	10.02	23
24	Clerical	1,403	5,053	50,529	10.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,915	108,252	$ 1,926,468 *	$ 17.80	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		$ 19,114	1,3	35
36	Medical Director		32,000	9,3	36
37	Medical Records Consultant		1,808	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,800	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		3,437	11,3	44
45	Social Service Consultant		2,187	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 64,346		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 Champaign # 0048181 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeff Baker	Administrator	0	$ 114,657
Brenda Dively	Asst. Admin.	0	45,400
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,057

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 196,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 196,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 2,568
Stein Law Offices	Legal Fees	4,150
O'Malley Hansen Communicatios	Counsel Fees	1,650
Livingston Barger Law Firm	Legal Fees	5,413
Much Shelist	Legal Fees	2,260
C.J. Schlosser & Company, LLC	Accounting Services	2,175
Surefire LTC		1,750
Heyl Royster	Legal Fees	156
Paycom Payroll	Payroll Processing	13,764
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 33,886

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,396
Unemployment Compensation Insurance	28,596
FICA Taxes	145,061
Employee Health Insurance	35,568
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,386
Employee Benefits	1,042
Related Party Allocation - Bridgemark	13,551
Related Party Allocation - NW Rehab	439
TOTAL (agree to Schedule V, line 22, col.8)	$ 265,039

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	3,449
Health Care Worker Background Check	4,754
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	6,832
Advertising	34,130
Miscellaneous Licenses & Fees	558
Related Party Allocation - Bridgemark	942
Less: Public Relations Expense	( )
Non-allowable advertising	(34,130)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,525

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,010
Seminar Expense	1,625
Related Party Allocation - Bridgemark	3,968
Related Party Allocation - NW Rehab	28
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,631

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/18 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 $5,306**

(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. $ **24,768** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **Yes**
If YES, give effective date of lease. **12/20/13**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **176,646**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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