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: 0046672

Facility Name: Helia Healthcare of Energy

Address: 210 East College (Number) Energy (City) 62933 (Zip Code)

County: Williamson

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 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 Energy # 0046672 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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	7	Intermediate (ICF)	7	2,555	3
4	48	Intermediate/DD	48	17,520	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,280	3,316	10,135	21,731	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,280	3,316	10,135	21,731	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.83%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/01/03

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 8,113

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 Energy # 0046672 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	163,113	10,591	6,961	180,665		180,665		180,665			1
2	Food Purchase		146,246		146,246		146,246	(110)	146,136			2
3	Housekeeping	106,534	23,802	7,875	138,211		138,211		138,211			3
4	Laundry	16,205	5,951	83,820	105,976		105,976	(13,994)	91,982			4
5	Heat and Other Utilities			128,095	128,095		128,095	(3,560)	124,535			5
6	Maintenance	47,809	10,955	42,585	101,349		101,349	51,516	152,865			6
7	Other (specify):*											7
8	TOTAL General Services	333,661	197,545	269,336	800,542		800,542	33,852	834,394			8
	B. Health Care and Programs											
9	Medical Director			17,322	17,322		17,322		17,322			9
10	Nursing and Medical Records	1,637,633	110,824	13,927	1,762,384		1,762,384	15,259	1,777,643			10
10a	Therapy		2,450		2,450		2,450	1,012	3,462			10a
11	Activities	43,806	5,927	4,906	54,639		54,639		54,639			11
12	Social Services	73,167	111	2,489	75,767		75,767		75,767			12
13	CNA Training											13
14	Program Transportation			7,722	7,722		7,722		7,722			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,754,606	119,312	46,366	1,920,284		1,920,284	16,271	1,936,555			16
	C. General Administration											
17	Administrative	95,034		281,500	376,534		376,534	(264,181)	112,353			17
18	Directors Fees											18
19	Professional Services			21,338	21,338		21,338	14,209	35,547			19
20	Dues, Fees, Subscriptions & Promotions			61,898	61,898		61,898	(41,658)	20,240			20
21	Clerical & General Office Expenses	71,035	22,831	119,569	213,435		213,435	117,944	331,379			21
22	Employee Benefits & Payroll Taxes			266,476	266,476		266,476	33,601	300,077			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,897	5,897		5,897	4,281	10,178			24
25	Other Admin. Staff Transportation			6,175	6,175		6,175	21,359	27,534			25
26	Insurance-Prop.Liab.Malpractice			97,574	97,574		97,574	1,262	98,836			26
27	Other (specify):*											27
28	TOTAL General Administration	166,069	22,831	860,427	1,049,327		1,049,327	(113,183)	936,144			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,254,336	339,688	1,176,129	3,770,153		3,770,153	(63,060)	3,707,093			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy #0046672 Report Period Beginning: 01/01/18 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			22,292	22,292		22,292	6,028	28,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,445	89,445		89,445	(16,772)	72,673			32
33	Real Estate Taxes			70,634	70,634		70,634	1,419	72,053			33
34	Rent-Facility & Grounds			485,962	485,962		485,962	9,056	495,018			34
35	Rent-Equipment & Vehicles			44,121	44,121		44,121	679	44,800			35
36	Other (specify):*											36
37	**TOTAL Ownership**			712,454	712,454		712,454	410	712,864			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		418,873	1,120,925	1,539,798		1,539,798	(1,470)	1,538,328			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			157,992	157,992		157,992		157,992			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		418,873	1,278,917	1,697,790		1,697,790	(1,470)	1,696,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,254,336	758,561	3,167,500	6,180,397		6,180,397	(64,120)	6,116,277			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	(14,337)	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	(16,787)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	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	(370)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,535)	21		19
20	Contributions	(1,250)	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	(37,463)	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	(4,898)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,750)		$	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)	14,630	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 14,630		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (64,120)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Energy

ID# 0046672

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (4,473)	20	1
2	To Eliminate Lobbying & PAC Dues	(2,355)	20	2
3	To Record IDPH Fees Paid in Prior Year	1,990	20	3
4	To Offest Medical Records Income	(60)	10	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**	(4,898)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	(110)	0	0	0	0	0	0	0	0	0	0	(110)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(13,994)	0	0	0	0	0	0	0	0	(13,994)	4
5	Heat and Other Utilities	(14,337)	451	10,326	0	0	0	0	0	0	0	0	(3,560)	5
6	Maintenance	0	0	51,516	0	0	0	0	0	0	0	0	51,516	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,447)	451	47,848	0	0	0	0	0	0	0	0	33,852	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	(60)	15,319	0	0	0	0	0	0	0	0	0	15,259	10
10a	Therapy	0	0	1,012	0	0	0	0	0	0	0	0	1,012	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**	(60)	15,319	1,012	0	0	0	0	0	0	0	0	16,271	16
	C. General Administration													
17	Administrative	0	(264,379)	198	0	0	0	0	0	0	0	0	(264,181)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,230	979	0	0	0	0	0	0	0	0	14,209	19
20	Fees, Subscriptions & Promotions	(42,671)	1,013	0	0	0	0	0	0	0	0	0	(41,658)	20
21	Clerical & General Office Expenses	(4,785)	119,696	3,033	0	0	0	0	0	0	0	0	117,944	21
22	Employee Benefits & Payroll Taxes	0	14,580	19,021	0	0	0	0	0	0	0	0	33,601	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,270	11	0	0	0	0	0	0	0	0	4,281	24
25	Other Admin. Staff Transportation	0	4,947	16,412	0	0	0	0	0	0	0	0	21,359	25
26	Insurance-Prop.Liab.Malpractice	0	874	388	0	0	0	0	0	0	0	0	1,262	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(47,456)	(105,769)	40,042	0	0	0	0	0	0	0	0	(113,183)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,963)	(89,999)	88,902	0	0	0	0	0	0	0	0	(63,060)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy # 0046672 **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	1,226	4,802	0	0	0	0	0	0	0	0	6,028	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,787)	0	15	0	0	0	0	0	0	0	0	(16,772)	32
33	Real Estate Taxes	0	43	1,376	0	0	0	0	0	0	0	0	1,419	33
34	Rent-Facility & Grounds	0	6,288	2,768	0	0	0	0	0	0	0	0	9,056	34
35	Rent-Equipment & Vehicles	0	0	679	0	0	0	0	0	0	0	0	679	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,787)	7,557	9,640	0	0	0	0	0	0	0	0	410	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(1,470)	0	0	0	0	0	0	0	0	(1,470)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(1,470)	0	0	0	0	0	0	0	0	(1,470)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,750)	(82,442)	97,072	0	0	0	0	0	0	0	0	(64,120)	45

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 Champaign	Champaign, 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, LLC	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%	$ 451	$ 451	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	15,319	15,319	2
3	V	17	Management Fees	281,500	Bridgemark Healthcare, LLC	100.00%	17,121	(264,379)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	13,230	13,230	4
5	V	20	Dues Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,013	1,013	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	119,696	119,696	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	14,580	14,580	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,270	4,270	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,947	4,947	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	874	874	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,226	1,226	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	43	43	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	6,288	6,288	13
14	Total			$ 281,500			$ 199,058	$ * (82,442)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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%	$ 574	$ 574	15
16	V								16
17	V	4	Laundry	83,820	Helia Healthcare Services	100.00%	69,826	(13,994)	17
18	V	5	Utilities		Helia Healthcare Services	100.00%	10,326	10,326	18
19	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	54,516	51,516	19
20	V	19	Professional Services		Helia Healthcare Services	100.00%	979	979	20
21	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	3,017	3,017	21
22	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	18,854	18,854	22
23	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	16,392	16,392	23
24	V	26	Insurance		Helia Healthcare Services	100.00%	388	388	24
25	V	30	Depreciation		Helia Healthcare Services	100.00%	4,802	4,802	25
26	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,376	1,376	26
27	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	2,768	2,768	27
28	V	35	Rent - Vehicle		Helia Healthcare Services	100.00%	105	105	28
29	V								29
30	V	39	Ancillary Services	1,470	NW Rehab, LLC	100.00%		(1,470)	30
31	V	10a	Therapy		NW Rehab, LLC	100.00%	1,012	1,012	31
32	V	17	Admin Salaries		NW Rehab, LLC	100.00%	198	198	32
33	V								33
34	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	16	16	34
35	V	22	Employee Benefits		NW Rehab, LLC	100.00%	167	167	35
36	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	11	11	36
37	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	20	20	37
38	V	32	Interest		NW Rehab, LLC	100.00%	15	15	38
39	Total			$ 88,290			$ 185,362	$ * 97,072	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	282,879	2.85	5.71	Distribution	$ 17,121	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	$ 17,121		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	$	21,731	$ 451	1
2	10	Nursing & Medical Supplies	Resident Days	380,780	15	268,418	268,418	21,731	15,319	2
3	17	Owner's Compensation	Resident Days	380,780	15	300,000		21,731	17,121	3
4	19	Professional Fees	Resident Days	380,780	15	231,817		21,731	13,230	4
5	20	Dues, Subscriptions	Resident Days	380,780	15	17,755		21,731	1,013	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	21,731	102,738	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		21,731	16,958	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	380,780	15	255,471		21,731	14,580	8
9	24	Seminars	Resident Days	380,780	15	74,815		21,731	4,270	9
10	25	Admin Staff Travel	Resident Days	380,780	15	86,690		21,731	4,947	10
11	26	Insurance	Resident Days	380,780	15	15,316		21,731	874	11
12	30	Depreciation	Resident Days	380,780	15	21,481		21,731	1,226	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		21,731	43	13
14	34	Building Rent	Resident Days	380,780	15	102,060		21,731	5,825	14
15	34	Storage Unit Rent	Resident Days	380,780	15	8,118		21,731	463	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		21,731	574	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		$ 199,632	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	86,820	$ 69,826	1
2	5	Utilities	Revenue	250,260	3	29,766		86,820	10,326	2
3	6	Maintenance	Revenue	250,260	3	157,143	147,458	86,820	54,516	3
4	19	Professional Services	Revenue	250,260	3	2,823		86,820	979	4
5	21	Clerical & Office Supplies	Revenue	250,260	3	8,696		86,820	3,017	5
6	22	Payroll Taxes & Emp Benefits	Revenue	250,260	3	54,347		86,820	18,854	6
7	25	Other Admin Transportation	Revenue	250,260	3	47,251		86,820	16,392	7
8	26	Insurance	Revenue	250,260	3	1,119		86,820	388	8
9	30	Depreciation	Revenue	250,260	3	13,843		86,820	4,802	9
10	33	Real Estate Taxes	Revenue	250,260	3	3,966		86,820	1,376	10
11	34	Rent - Facility	Revenue	250,260	3	7,980		86,820	2,768	11
12	35	Rent - Vehicle	Revenue	250,260	3	303		86,820	105	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		$ 183,349	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 & Medical Records	Revenue	2,717,752	19	$ 792	$	1,470	$	1
2	10a	Therapy	Revenue	2,717,752	19	1,870,778	1,870,778	1,470	1,012	2
3	17	Admin Salaries	Revenue	2,717,752	19	366,622	366,622	1,470	198	3
4	20	Dues & Subscriptions	Revenue	2,717,752	19	41		1,470		4
5	21	Clerical & Office Supplies	Revenue	2,717,752	19	30,294		1,470	16	5
6	22	Employee Benefits	Revenue	2,717,752	19	308,794		1,470	167	6
7	24	Travel & Seminar	Revenue	2,717,752	19	19,790		1,470	11	7
8	25	Other Admin Transp	Revenue	2,717,752	19	37,856		1,470	20	8
9	32	Interest	Revenue	2,717,752	19	28,025		1,470	15	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		$ 1,439	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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	89,445	6
7												7
8	Related Party Allocation										15	8
9	TOTAL Facility Related						$	$			$ 89,460	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(16,787)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,787)	14
15	TOTALS (line 9+line14)						$	$			$ 72,673	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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.**	$ 73,975	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.)		$ 95,825	2
3. Under or (over) accrual (line 2 minus line 1).		$ 21,850	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,784	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.		$ 70,634	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	68,822	8
2014	70,423	9
2015	72,073	10
2016	72,929	11
2017	70,634	12

70,634	Line 7, Real Estate Tax Portion of Lease Payment	
43	Bridgemark Healthcare Allocation	
1,376	Helia Healthcare Allocation	
72,053	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 Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 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.	06-06-227-019	Long Term Care	$ 70,634.20	$ 70,634.20
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,634.20	$ 70,634.20

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 Energy # 0046672 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation - Helia Healthcare			$ 1,738	1
2					2
3	TOTALS			$ 1,738	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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		$ 46,326	$	25	$ 2,316	$ 2,316	$ 10,532	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	"C" Wing Signs			2004	1,752						10
11	Handrail Molding			2004	1,000						11
12	Wallpaper			2004	1,740						12
13	Wallpaper			2004	1,062						13
14	Room Signs			2004	1,357						14
15	Paint Boarder			2004	2,253						15
16	Door Handles & Knobs			2004	729						16
17	Boarder for B Wing			2004	582						17
18	Wallpaper for C Wing			2004	1,107						18
19	Handrails, Brackets			2004	1,093						19
20	Wire Smoke Detectors			2004	572						20
21	Door knobs, B & C Wing			2004	766						21
22	2 Wall A/C Units			2005	1,035						22
23	Roof Top HVAC Unit			2006	13,757						23
24	5 Wall A/C			2006	3,242						24
25	Smoke Detectors			2006	749						25
26	Fence			2006	573						26
27	Glass Door & Install			2007	1,210						27
28	Roof Top HVAC Unit			2007	17,623						28
29	80 Gallon Water Heater			2007	2,829						29
30	Trailor for Resident Smokers			2008	1,295						30
31	Doors			2008	8,553						31
32	Wall Air Conditioner			2008	3,040						32
33	3 Wall A/C Units			2009	3,686						33
34	New Doors, Flooring, Wallcovering for entrance & Wing			2009	56,401						34
35	Roof Repair			2009	2,000						35
36	Call Cords			2009	1,255						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	Exterior Brickwork Improvements	2010	$ 7,712	$		$	$	$	37
38	New Asphalt Parking Lot	2010	22,840						38
39	Heat/ Water Pump System	2010	9,800						39
40	A/C Compressor Replacement	2010	1,999						40
41	Fire Protect System: Arch Wing	2010	7,971						41
42	15 Heat/ Cool Wall Units	2010	7,753						42
43	10 Heat/ Cool Wall Units	2010	5,530						43
44	Phone System	2010	17,144						44
45	S Hall (22rms) - New doors, windows, bathrooms, paint, drywall	2011	56,140						45
46	W Hall (6rms) - new doors, windows, bathrooms, paint, drywall	2011	22,456						46
47	Nursing Station Improve- new cabinets, counter, wiring, floor	2011	22,456						47
48	Dining Room- flooring, drywall, lighting fixtures, paint	2011	33,684						48
49	Resident lounge area- electrical, lighting, fixtures, drywall, paint	2011	22,456						49
50	Resident Kitchen area - New sinks, flooring, wiring, drywall, paint	2011	11,228						50
51	Therapy Room- Flooring, drywall, paint, lighting, window, labor	2011	22,456						51
52	2 Shower Rooms - Tile, shower heads, fixtures, paint, new plumbir	2011	33,684						52
53	Arch (rehab) unit - labor, doors, windows, drywall, paint, flooring								53
54	(cont.) fire alarms, plumbing, architect fees	2011	70,667						54
55	Exterior Brickwork Improvements	2011	3,600						55
56	21 Wall A/C Units	2012	8,691						56
57	New Central Air unit on A Wing	2012	2,700						57
58	Flooring	2012	1,780						58
59	Door Monitors & Keypads	2012	1,707						59
60	Heat/ Cool Wall Units	2012	4,580						60
61	Bed Additions in ARCH Unit	2013	34,951						61
62	Heating/ Cool Units	2013	3,919						62
63									63
64	4 A/C Units	2014	2,586	518	5	518		2,112	64
65	Tile, paint, vanities, toilets - A Wing	2014	3,971	397	10	397		1,952	65
66	Windows, Tile Door & Vanities	2014	3,584	359	10	359		1,673	66
67	A Wing Nurses Station	2014	1,450	145	10	145		641	67
68	Windows, Laminate tops, paint, tile B Wing	2014	15,282	1,019	15	1,019		4,075	68
69	Kitchen, wiring install	2014	990	99	10	99		487	69
70	TOTAL (lines 4 thru 69)		$ 643,354	$ 2,537		$ 4,853	$ 2,316	$ 21,472	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	
1	Totals from Page 12A, Carried Forward		$ 643,354	$ 2,537		$ 4,853	$ 2,316	$ 21,472	1
2	CTS Tech Phone Line Upgrade/Cabeling Install	2014	5,113	511	10	511		2,492	2
3	Security I - Alarm System Install	2014	1,950	195	10	195		861	3
4	Windows	2014	925	93	10	93		393	4
5	A Wing Remodel Floor/Tile/Paint	2015	5,594	372	15	372		1,461	5
6	Kitchen Flooring & Laminate Countertops	2015	5,272	351	15	351		1,172	6
7	Vinyl Tile - A Wing	2016	9,121	912	10	912		2,584	7
8	Fire Alarm Replacement & 12 yr Suppression	2016	5,293	529	10	529		1,456	8
9	ARCH Remodel - labor, doors, windows, drywall, paint								9
10	(cont.) flooring, fire alarms, plumbing, architect fees	2016	99,999	5,000	20	5,000		15,000	10
11	Front Door	2017	3,217	322	10	322		563	11
12	Therapy Room/ ARCH Remodel - paint, trim, doors	2017	13,970	519	20	519		894	12
13	300kw Cat Generator Install & Electric	2018	9,143	457	5	457		457	13
14									14
15									15
16									16
17	Related Party Allocation - Bridgemark Healthcare LLC								17
18	New Office Build-Out	2011	7,751		20	410	410	3,059	18
19	Conference Rm Chair Rail & Paint	2012	88		5			88	19
20	AC Unit in Server Room	2018	601		20	15	15	15	20
21									21
22									22
23	Related Part Allocation - Helia Healthcare								23
24	Water & Sewer Pipe Installation	2006	659		20	33	33	409	24
25	Plumbing & Heating Installation	2006	789		20	40	40	490	25
26	A/C Unit - 4 Ton	2007	1,901		10			1,901	26
27	400 Gal. Water Storage Tank	2016	5,364		10	536	536	1,296	27
28	AC Compressor at Martin's Catering Building	2018	867		15	29	29	29	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 820,971	$ 11,798		$ 15,177	$ 3,379	$ 56,092	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	$ 77,765	$ 9,270	$ 11,754	$ 2,484	3-15	$ 35,894	71
72	Current Year Purchases	18,499	603	768	165	3-15	768	72
73	Fully Depreciated Assets	34,743					34,743	73
74								74
75	TOTALS	$ 131,007	$ 9,873	$ 12,522	$ 2,649		$ 71,405	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility		2014	$ 9,938	$ 621	$ 621	$	4	$ 9,938	76
77	Related Party Allocation - Bridgemark		2005	758				4	758	77
78	Related Party Allocation - Helia Healthcare		2006	2,329				4	2,329	78
79										79
80	TOTALS			$ 13,025	$ 621	$ 621	$		$ 13,025	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)	$ 966,741	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,292	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 28,320	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,028	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 140,522	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Energy 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:		139	5/7/18	$ 485,962			3
4	Additions							4
5	Related Party Allocations				9,056			5
6								6
7	TOTAL		139		$ 495,018 **			7

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	$

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: *

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: $ 44,800 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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				2,450		2,450	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				391,572		391,572	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					27,301		27,301	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				1,119,455			1,119,455	13
14	TOTAL			$		$ 1,119,455	$ 421,323		$ 1,540,778	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 Energy # 0046672 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	$ 1,701	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	894,764		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,673		7
8	Accounts Receivable (owners or related parties)	109,683		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,010,821	$	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	183,950		15
16	Equipment, at Historical Cost	108,747		16
17	Accumulated Depreciation (book methods)	(94,729)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	48,784		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 246,752	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,257,573	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,485,849	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,211		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,806		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,784		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessments	6,779		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,690,429	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	180,106		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 180,106	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,870,535	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,612,962)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,257,573	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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**	$ (1,040,086)	1
2	Restatements (describe):		2
3	**Prior Year adjustments made after cost report submitted**	(481,540)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,521,626)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(91,336)	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)**	$ (91,336)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,612,962)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	$ 6,019,533	1
2	Discounts and Allowances for all Levels	(205,244)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,814,289	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	206,133	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 206,133	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***	16,787	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,787	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous & late fee forgiveness**	51,792	28
28a	**Medical Record Copies**	60	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,852	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,089,061	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	800,542	31
32	Health Care	1,920,284	32
33	General Administration	1,049,327	33
	B. Capital Expense		
34	Ownership	712,454	34
	C. Ancillary Expense		
35	Special Cost Centers	1,539,798	35
36	Provider Participation Fee	157,992	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,180,397	40
41	**Income before Income Taxes (line 30 minus line 40)****	(91,336)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (91,336)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,145,048	44
45	Private Pay - Net Inpatient Revenue	489,090	45
46	Medicare - Net Inpatient Revenue	3,699,075	46
47	Other-(specify) **Insurance**	480,581	47
48	Other-(specify) **Hospice**	495	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,814,289	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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	1,887	2,079	$ 95,579	$ 45.97	1
2	Assistant Director of Nursing	1,495	1,735	56,644	32.65	2
3	Registered Nurses	13,950	14,982	465,651	31.08	3
4	Licensed Practical Nurses	13,488	14,424	346,506	24.02	4
5	CNAs & Orderlies	44,046	46,770	587,701	12.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	374	374	4,512	12.06	8
9	Activity Director					9
10	Activity Assistants	3,231	3,500	43,806	12.52	10
11	Social Service Workers	3,710	3,972	73,167	18.42	11
12	Dietician					12
13	Food Service Supervisor	2,074	2,189	28,458	13.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,853	11,500	134,655	11.71	15
16	Dishwashers					16
17	Maintenance Workers	1,964	2,227	47,809	21.47	17
18	Housekeepers	7,880	8,696	106,534	12.25	18
19	Laundry	1,624	1,624	16,205	9.98	19
20	Administrator	1,766	2,032	82,657	40.68	20
21	Assistant Administrator	494	570	12,377	21.71	21
22	Other Administrative					22
23	Office Manager	1,938	2,118	53,242	25.14	23
24	Clerical	466	516	17,793	34.48	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)	3,175	3,487	48,739	13.98	30
31	Medical Records	2,162	2,370	32,301	13.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,577	125,165	$ 2,254,336 *	$ 18.01	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		$ 6,961	1, 3	35
36	Medical Director		17,322	9, 3	36
37	Medical Records Consultant		2,620	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,136	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		4,906	11, 3	44
45	Social Service Consultant		2,489	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 36,434		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 Energy # 0046672 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yolanda Fisher	Administrator	0	$ 82,657
Judy Minor	Asst. Admin	0	12,377
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,034

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 281,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 281,500

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting	$ 2,735
Personnel Planners	Unemployment Consulting	1,893
Much Shelist	Legal Fees	330
Steven B Pearlman & Associates	Legal Fees	962
Stein Law Office	Legal Fees	812
Paycom Payroll	Payroll Processing	14,606
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 21,338

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,509
Unemployment Compensation Insurance	31,987
FICA Taxes	171,431
Employee Health Insurance	36,427
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	4,858
Employee Benefits	264
Related Party Allocation - Bridgemark	14,580
Related Party Allocation - Helia	18,854
Related Party Allocation - NW Rehab	167
TOTAL (agree to Schedule V, line 22, col.8)	$ 300,077

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	3,708
Health Care Worker Background Check	4,952
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	8,047
Miscellaneous Licenses & Fees	530
Advertising	37,463
Related Party Allocation - Bridgemark	1,013
Less: Public Relations Expense	( )
Non-allowable advertising	(37,463)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,240

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,532
Seminar Expense	2,365
Related Party Allocation - Bridgemark	4,270
Related Party Allocation - NW Rehab	11
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,178

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/18 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 $5,034**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,457** 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. **12/30/13**

(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. $ **157,992**
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? **None** Indicate the amount. $ **N/A**

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

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

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

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

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

	Description	
16A	Nursing Equipment	30,836
16B	Copier Lease	11,415
16C	Dietary Equipment	8
16D	Related Party Allocation - Bridgemark Healthcare	574
16E	Related Party Allocation - Helia Healthcare	105
16F	Computers & Software	1,862
		44,800