

Facility Name & ID Number Helia Hlthcare of Champaign

0048181 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	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	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,242	2,228	2,946	19,416	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,242	2,228	2,946	19,416	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.96%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold 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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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 Date 05/01/06 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 118 and days of care provided 1,197

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,986	16,656	6,454	162,096		162,096		162,096		1
2	Food Purchase		118,304		118,304		118,304	(67)	118,237		2
3	Housekeeping	76,030	13,188	1,887	91,105		91,105		91,105		3
4	Laundry	33,648	11,676	91	45,415		45,415		45,415		4
5	Heat and Other Utilities			128,278	128,278		128,278	(29,192)	99,086		5
6	Maintenance	42,718	16,263	83,931	142,912		142,912		142,912		6
7	Other (specify):*										7
8	TOTAL General Services	291,382	176,087	220,641	688,110		688,110	(29,259)	658,851		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,068,581	77,259	29,042	1,174,882		1,174,882	9,740	1,184,622		10
10a	Therapy		317		317		317		317		10a
11	Activities	31,694	5,091	3,327	40,112		40,112		40,112		11
12	Social Services	44,588	685	2,150	47,423		47,423		47,423		12
13	CNA Training										13
14	Program Transportation			4,764	4,764		4,764		4,764		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,144,863	83,352	57,283	1,285,498		1,285,498	9,740	1,295,238		16
	C. General Administration										
17	Administrative	138,528		158,900	297,428		297,428	(139,934)	157,494		17
18	Directors Fees										18
19	Professional Services			16,427	16,427		16,427	3,053	19,480		19
20	Dues, Fees, Subscriptions & Promotions			79,637	79,637		79,637	(54,351)	25,286		20
21	Clerical & General Office Expenses	51,831	18,570	116,905	187,306		187,306	100,077	287,383		21
22	Employee Benefits & Payroll Taxes			275,050	275,050		275,050	15,688	290,738		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,959	2,959		2,959	3,637	6,596		24
25	Other Admin. Staff Transportation			5,748	5,748		5,748	4,668	10,416		25
26	Insurance-Prop.Liab.Malpractice			99,261	99,261		99,261	745	100,006		26
27	Other (specify):*										27
28	TOTAL General Administration	190,359	18,570	754,887	963,816		963,816	(66,417)	897,399		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,626,604	278,009	1,032,811	2,937,424		2,937,424	(85,936)	2,851,488		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 Hlthcare of Champaign

#0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,288	18,288		18,288	1,257	19,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,671	43,671		43,671	(321)	43,350			32
33	Real Estate Taxes			37,143	37,143		37,143	14	37,157			33
34	Rent-Facility & Grounds			325,412	325,412		325,412	5,812	331,224			34
35	Rent-Equipment & Vehicles			10,052	10,052		10,052	576	10,628			35
36	Other (specify):* Loss on disposal			2,082	2,082		2,082		2,082			36
37	TOTAL Ownership			436,648	436,648		436,648	7,338	443,986			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,508	322,386	423,894		423,894		423,894			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,618	177,618		177,618		177,618			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		101,508	500,004	601,512		601,512		601,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,626,604	379,517	1,969,463	3,975,584		3,975,584	(78,598)	3,896,986			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 Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(29,327)	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	(321)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	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	(1,430)	21		18
19	Entertainment	(1,361)	21		19
20	Contributions				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	(45,642)	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	(8,575)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,470)		\$	30

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	2	
		Amount	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)	8,872	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,872		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (78,598)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Hlthcare of Champaign

ID# 0048181

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	\$ (2,209)	20	1
2	Eliminate Lobbying & PAC Due	(3,076)	20	2
3	Offset Medical Records Income	(179)	10	3
4	Add 2016 IDPH License Paid in 2015	1,990	20	4
5	Eliminate Advertising	(5,101)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,575)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Champaign# 0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(67)	0	0	0	0	0	0	0	0	0	0	(67)	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	(29,327)	135	0	0	0	0	0	0	0	0	0	(29,192)	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	(29,394)	135	0	(29,259)	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	(179)	9,919	0	0	0	0	0	0	0	0	0	9,740	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	(179)	9,919	0	9,740	16								
	C. General Administration													
17	Administrative	0	(139,934)	0	0	0	0	0	0	0	0	0	(139,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,053	0	0	0	0	0	0	0	0	0	3,053	19
20	Fees, Subscriptions & Promotions	(54,785)	434	0	0	0	0	0	0	0	0	0	(54,351)	20
21	Clerical & General Office Expenses	(2,791)	102,868	0	0	0	0	0	0	0	0	0	100,077	21
22	Employee Benefits & Payroll Taxes	0	15,688	0	0	0	0	0	0	0	0	0	15,688	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,637	0	0	0	0	0	0	0	0	0	3,637	24
25	Other Admin. Staff Transportation	0	4,668	0	0	0	0	0	0	0	0	0	4,668	25
26	Insurance-Prop.Liab.Malpractice	0	745	0	0	0	0	0	0	0	0	0	745	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(57,576)	(8,841)	0	(66,417)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,149)	1,213	0	(85,936)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	1,257	0	0	0	0	0	0	0	0	0	1,257	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(321)	0	0	0	0	0	0	0	0	0	0	(321)	32
33	Real Estate Taxes	0	14	0	0	0	0	0	0	0	0	0	14	33
34	Rent-Facility & Grounds	0	5,812	0	0	0	0	0	0	0	0	0	5,812	34
35	Rent-Equipment & Vehicles	0	0	576	0	0	0	0	0	0	0	0	576	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(321)	7,083	576	0	7,338	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(87,470)	8,296	576	0	(78,598)	45							

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 Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthcare of Greenville	Greenville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Franfort, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 135	\$	135	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	9,919		9,919	2
3	V	17 Management Fees	158,900	Bridgemark Healthcare, LLC	100.00%	18,966		(139,934)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	3,053		3,053	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	434		434	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	102,868		102,868	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	15,688		15,688	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,637		3,637	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,668		4,668	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	745		745	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,257		1,257	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	14		14	12
13	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	5,812		5,812	13
14	Total		\$ 158,900			\$ 167,196	\$ *	8,296	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 576	\$	576	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 576	\$ *	576	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Helia Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Helia Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	342,577	2.62	5.25	Distribution	\$ 18,966	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	\$ 18,966		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 Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Resident Days	370,125	13	\$ 2,569	\$ 19,416	\$ 135	1	
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	189,088	19,416	9,919	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		19,416	18,966	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		19,416	3,053	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280		19,416	434	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	19,416	82,660	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		19,416	20,208	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		19,416	15,688	8
9	24	Seminars	Resident Days	370,125	13	69,325		19,416	3,637	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		19,416	4,668	10
11	26	Insurance	Resident Days	370,125	13	14,200		19,416	745	11
12	30	Depreciation	Resident Days	370,125	13	23,966		19,416	1,257	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		19,416	14	13
14	34	Building Rent	Resident Days	370,125	13	102,424		19,416	5,373	14
15	34	Rental - Storage Unit	Resident Days	370,125	13	8,376		19,416	439	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		19,416	576	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,198,219	\$ 1,764,830	\$ 167,772		25

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Hlthcare 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>45-20-22-282-005</u>	<u>Long Term Care</u>	\$ <u>36,594.54</u>	\$ <u>36,594.54</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>36,594.54</u></u>	\$ <u><u>36,594.54</u></u>

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

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. (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 1: Section N/A, Row 2: (blank), Row 3: TOTALS

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Prior Owner Costs:								
10	Concrete		2006	2,907					
11	Commercial Floor Covering		2006	5,183					
12	Wall A/C Units		2006	3,347					
13	Roofing - D & R Roofing		2007	20,600					
14	Pipes		2007	8,346					
15	Life Safety Detectors & Lighted Exit Sign		2007	3,871					
16	A/C Units		2007	3,039					
17	Heating & A/C Compressor & A/C Units		2008	7,072					
18	Roof Top A/C & Roof Repairs		2008	7,347					
19	Door, Sign & Emergence Back-up Lights		2009	4,174					
20	Remodel Hall A - New Doors, flooring rails & upgrade nurses station		2009	14,343					
21	Modern Tile		2010	4,243					
22	Carpet/Tile		2010	9,457					
23	Hot Water Heater		2011	6,504					
24	Roof Top HVAC Unit		2012	6,700					
25	Fire Alarm Panel		2013	7,938					
26									
27	Installed new phone/internet wiring throughtout facility		2014	11,000	733	15	733		1,955
28	Lumber for handrails made and installed in the A & B wings		2014	3,520	235	15	235		567
29	Install handrails, cabinets, sinks, doors, & carpet - A & B wings		2014	6,190	413	15	413		963
30	DS - Emergency Light		2014	223	22	10	22		50
31	ARCH (Rehab) Unit - labor, doors, windows, drywall, paint, flooring,								
32	(cont.) fire alarms, plumbing, architect fees - wings C & D converted		2016	618,036	2,575	20	2,575		2,575
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								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								70
TOTAL (lines 4 thru 69)								

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 47,164	\$ 8,690	\$ 9,533	\$ 843	3-15	\$ 23,125	71
72	Current Year Purchases	164,734	5,620	5,641	21	3-15	5,641	72
73	Fully Depreciated Assets	4,516					4,516	73
74								74
75	TOTALS	\$ 216,414	\$ 14,310	\$ 15,174	\$ 864		\$ 33,282	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				\$	\$	\$	\$		\$	76
77	Related Party Allocation - Bridgemark		2005	697				4	697	77
78										78
79										79
80	TOTALS			\$ 697	\$	\$	\$		\$ 697	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)	\$ 978,357	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,288	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,545	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,257	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 42,216	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Champaign, Williamson, Franklin, L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	118		\$ 314,063			3
4	Additions						4
5	Related Party Allocation - Bridgemark			5,812			5
6	Storage Rental			11,349			6
7	TOTAL	118		\$ 331,224			7

10. Effective dates of current rental agreement:

Beginning 12/20/13

Ending 12/19/23

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

Fiscal Year Ending Annual Rent

12.	<u>/2017</u>	\$ <u>294,000</u>
13.	<u>/2018</u>	\$ <u>294,000</u>
14.	<u>/2019</u>	\$ <u>294,000</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A. N/A

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 10,628 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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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				317		317	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				83,998		83,998	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39,2					17,510		17,510	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3				322,386			322,386	13
14	TOTAL			\$		\$ 322,386	\$ 101,825		\$ 424,211	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/16**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 892	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>232,778</u>)	1,021,827		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,733		7
8	Accounts Receivable (owners or related parties)	683,431		8
9	Other(specify): <u>Deposits</u>	78,981		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,802,864	\$	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	648,119		15
16	Equipment, at Historical Cost	197,505		16
17	Accumulated Depreciation (book methods)	(31,993)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	39,900		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 853,531	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,656,395	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 755,440	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,096		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,939		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,898		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Parties</u>	973		36
37	<u>Accrued Provider Assessment</u>	17,810		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 920,156	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 920,156	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,736,239	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,656,395	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,588,272	1
2	Restatements (describe):		2
3	Prior Year Adjustment for Workers Comp Audit	84,339	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,672,611	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(936,372)	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)	\$ (936,372)	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)	\$ 1,736,239	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,066,672	1
2	Discounts and Allowances for all Levels	(137,344)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,929,328	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,418	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 129,418	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***	321	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 321	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	(20,034)	28
28a	<u>Medical Record Copies</u>	179	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (19,855)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,039,212	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	688,110	31
32	Health Care	1,285,498	32
33	General Administration	963,816	33
B. Capital Expense			
34	Ownership	436,648	34
C. Ancillary Expense			
35	Special Cost Centers	423,894	35
36	Provider Participation Fee	177,618	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,975,584	40
41	Income before Income Taxes (line 30 minus line 40)**	(936,372)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (936,372)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,516,192	44
45	Private Pay - Net Inpatient Revenue	437,916	45
46	Medicare - Net Inpatient Revenue	564,391	46
47	Other-(specify) <u>Insurance</u>	341,984	47
48	Other-(specify) <u>Hospice</u>	68,845	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,929,328	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 Hlthcare of Champaign

0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,846	2,005	\$ 68,564	\$ 34.20	1
2	Assistant Director of Nursing	209	209	6,246	29.89	2
3	Registered Nurses	7,857	8,272	237,698	28.74	3
4	Licensed Practical Nurses	11,375	12,349	306,524	24.82	4
5	CNAs & Orderlies	30,112	32,360	420,139	12.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,530	1,716	29,410	17.14	8
9	Activity Director					9
10	Activity Assistants	1,917	2,088	31,694	15.18	10
11	Social Service Workers	2,546	3,169	44,588	14.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,419	11,178	138,986	12.43	15
16	Dishwashers					16
17	Maintenance Workers	1,906	2,129	42,718	20.06	17
18	Housekeepers	6,478	7,094	76,030	10.72	18
19	Laundry	3,324	3,571	33,648	9.42	19
20	Administrator	1,937	2,085	88,480	42.44	20
21	Assistant Administrator	1,942	2,206	50,048	22.69	21
22	Other Administrative	1,604	1,659	51,831	31.24	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	85,002	92,090	\$ 1,626,604 *	\$ 17.66	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 6,454	1,3	35
36	Medical Director	18,000	9,3	36
37	Medical Records Consultant	1,827	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,755	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	3,327	11,3	44
45	Social Service Consultant	2,150	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 36,513		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

Facility Name & ID Number Helia Hlthcare of Champaign# 0048181

Report Period Beginning:

01/01/16

Ending:

12/31/16**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 \$4,712
- (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? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,078 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. \$ 177,618
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.
- (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

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Champaign
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

Description		
16A	Nursing Equipment	4,725
16B	Copier Lease	5,327
16C	Related Party Allocation - Bridgemark Healthcare	576
		<u>10,628</u>