

Facility Name & ID Number Helia Healthcare of Olney

0050757 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	17,775	3,276	4,757	25,808	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,775	3,276	4,757	25,808	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.76%

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 04/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/10 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 4,157

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 Healthcare of Olney # 0050757 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	144,974	11,207	7,417	163,598		163,598		163,598		1
2	Food Purchase		136,979		136,979		136,979	(86)	136,893		2
3	Housekeeping	111,288	22,105	800	134,193		134,193		134,193		3
4	Laundry	27,855	19,085		46,940		46,940		46,940		4
5	Heat and Other Utilities			106,513	106,513		106,513	(11,564)	94,949		5
6	Maintenance	33,879	23,704	60,114	117,697		117,697		117,697		6
7	Other (specify):*										7
8	TOTAL General Services	317,996	213,080	174,844	705,920		705,920	(11,650)	694,270		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,108,538	89,588	25,755	1,223,881		1,223,881	12,664	1,236,545		10
10a	Therapy										10a
11	Activities	20,453	3,967	4,742	29,162		29,162	(383)	28,779		11
12	Social Services	29,674	746	2,512	32,932		32,932		32,932		12
13	CNA Training										13
14	Program Transportation			21,028	21,028		21,028		21,028		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,158,665	94,301	66,037	1,319,003		1,319,003	12,281	1,331,284		16
	C. General Administration										
17	Administrative	74,679		232,500	307,179		307,179	(207,290)	99,889		17
18	Directors Fees										18
19	Professional Services			15,842	15,842		15,842	3,813	19,655		19
20	Dues, Fees, Subscriptions & Promotions			85,577	85,577		85,577	(55,758)	29,819		20
21	Clerical & General Office Expenses	40,433	31,500	100,419	172,352		172,352	135,308	307,660		21
22	Employee Benefits & Payroll Taxes			264,342	264,342		264,342	20,853	285,195		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,557	2,557		2,557	4,834	7,391		24
25	Other Admin. Staff Transportation			1,615	1,615		1,615	6,204	7,819		25
26	Insurance-Prop.Liab.Malpractice			95,651	95,651		95,651	990	96,641		26
27	Other (specify):*										27
28	TOTAL General Administration	115,112	31,500	798,503	945,115		945,115	(91,046)	854,069		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,591,773	338,881	1,039,384	2,970,038		2,970,038	(90,415)	2,879,623		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Olney

#0050757

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			34,854	34,854		34,854	3,627	38,481		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			350,814	350,814		350,814		350,814		32
33	Real Estate Taxes			69,295	69,295		69,295	19	69,314		33
34	Rent-Facility & Grounds			725,654	725,654		725,654	8,477	734,131		34
35	Rent-Equipment & Vehicles			14,623	14,623		14,623	(12,702)	1,921		35
36	Other (specify):*										36
37	TOTAL Ownership			1,195,240	1,195,240		1,195,240	(579)	1,194,661		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		223,084	650,869	873,953		873,953		873,953		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			188,012	188,012		188,012		188,012		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		223,084	838,881	1,061,965		1,061,965		1,061,965		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,591,773	561,965	3,073,505	5,227,243		5,227,243	(90,994)	5,136,249		45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney

0050757

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	(383)	11		4
5	Telephone, TV & Radio in Resident Rooms	(11,743)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(86)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(150)	21		18
19	Entertainment	(975)	21		19
20	Contributions	(319)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(246)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(47,196)	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	(9,660)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,758)		\$	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)	(20,236)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,236)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (90,994)		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	

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Olney

ID# 0050757

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	\$ (4,073)	20	1
2	Eliminate Lobbying & PAC Dues	(3,076)	20	2
3	Offset Medical Record Income	(521)	10	3
4	Eliminate IDPH Fees Disallowed	(1,990)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,660)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Olney

0050757

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	(86)	0	0	0	0	0	0	0	0	0	0	(86)	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	(11,743)	179	0	0	0	0	0	0	0	0	0	(11,564)	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	(11,829)	179	0	0	0	0	0	0	0	0	0	(11,650)	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	(521)	13,185	0	0	0	0	0	0	0	0	0	12,664	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(383)	0	0	0	0	0	0	0	0	0	0	(383)	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	(904)	13,185	0	0	0	0	0	0	0	0	0	12,281	16
	C. General Administration													
17	Administrative	0	(207,290)	0	0	0	0	0	0	0	0	0	(207,290)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(246)	4,059	0	0	0	0	0	0	0	0	0	3,813	19
20	Fees, Subscriptions & Promotions	(56,335)	577	0	0	0	0	0	0	0	0	0	(55,758)	20
21	Clerical & General Office Expenses	(1,444)	136,733	19	0	0	0	0	0	0	0	0	135,308	21
22	Employee Benefits & Payroll Taxes	0	20,853	0	0	0	0	0	0	0	0	0	20,853	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,834	0	0	0	0	0	0	0	0	0	4,834	24
25	Other Admin. Staff Transportation	0	6,204	0	0	0	0	0	0	0	0	0	6,204	25
26	Insurance-Prop.Liab.Malpractice	0	990	0	0	0	0	0	0	0	0	0	990	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,025)	(33,040)	19	0	(91,046)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,758)	(19,676)	19	0	(90,415)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	1,671	1,956	0	0	0	0	0	0	0	0	3,627	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	19	0	0	0	0	0	0	0	0	0	19	33
34	Rent-Facility & Grounds	0	7,726	751	0	0	0	0	0	0	0	0	8,477	34
35	Rent-Equipment & Vehicles	0	0	(12,702)	0	0	0	0	0	0	0	0	(12,702)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	9,416	(9,995)	0	0	0	0	0	0	0	0	(579)	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)	(70,758)	(10,260)	(9,976)	0	0	0	0	0	0	0	0	(90,994)	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 Benton	Benton, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, 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 Belleville	Belleville, 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 Frankfort, 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%	\$ 179	\$	179	1
2	V	10 Nursing & Medial Records		Bridgemark Healthcare, LLC	100.00%	13,185		13,185	2
3	V	17 Management Fees	232,500	Bridgemark Healthcare, LLC	100.00%	25,210		(207,290)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	4,059		4,059	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	577		577	5
6	V	21 Clerical & General Offie		Bridgemark Healthcare, LLC	100.00%	136,733		136,733	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	20,853		20,853	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,834		4,834	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	6,204		6,204	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	990		990	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,671		1,671	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	19		19	12
13	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	7,726		7,726	13
14	Total		\$ 232,500			\$ 222,240	\$ *	(10,260)	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	21 Clerical & Office Supplies	\$	Bridgemark Medical Supply	100.00%	\$ 19	\$	19	15
16	V	30 Depreciation		Bridgemark Medical Supply	100.00%	1,956		1,956	16
17	V	34 Building Rent		Bridgemark Medical Supply	100.00%	751		751	17
18	V	35 Equipment Rental	13,468	Bridgemark Medical Supply	100.00%			(13,468)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	766		766	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		\$ 13,468			\$ 3,492	\$ *	(9,976)	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 Olney

0050757

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 Healthcare of Olney # 0050757 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	336,333	3.49	6.97	Distribution	\$ 25,210	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	\$ 25,210		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 Olney

0050757

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 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	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	Rental Days	370,125	13	\$ 2,569	\$ 25,808	\$ 179	1	
2	10	Nursing & Medical Records	Rental Days	370,125	13	189,088	189,088	25,808	13,185	2
3	17	Owners Compensation	Rental Days	370,125	13	361,543		25,808	25,210	3
4	19	Professional Fees	Rental Days	370,125	13	58,207		25,808	4,059	4
5	20	Dues, Subscriptions	Rental Days	370,125	13	8,280		25,808	577	5
6	21	Salaries - Other	Rental Days	370,125	13	1,575,742	1,575,742	25,808	109,873	6
7	21	Clerical & Office Supplies	Rental Days	370,125	13	385,214		25,808	26,860	7
8	22	Emp Benefits & Payroll Taxes	Rental Days	370,125	13	299,056		25,808	20,853	8
9	24	Seminars	Rental Days	370,125	13	69,325		25,808	4,834	9
10	25	Admin Staff Travel	Rental Days	370,125	13	88,978		25,808	6,204	10
11	26	Insurance	Rental Days	370,125	13	14,200		25,808	990	11
12	30	Depreciation	Rental Days	370,125	13	23,966		25,808	1,671	12
13	33	Real Estate Taxes	Rental Days	370,125	13	267		25,808	19	13
14	34	Building Rent	Rental Days	370,125	13	102,424		25,808	7,142	14
15	34	Rental - Storage Unit	Rental Days	370,125	13	8,376		25,808	584	15
16	35	Equipment Rental	Rental Days	370,125	13	10,984		25,808	766	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	\$ 223,006		25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney

0050757

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Bridgemark Medical Supply

Street Address

City / State / Zip Code

Phone Number

Fax Number

()

()

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	21	Clerical & Office Supplies	Revenue	121,165	7	\$ 168	\$ 13,468	\$ 19	1
2	30	Depreciation	Revenue	121,165	7	17,596	13,468	1,956	2
3	34	Building Rent	Revenue	121,165	7	6,757	13,468	751	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 24,521	\$	\$ 2,726	25

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Olney COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0050757

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>06-27-450-002</u>	<u>Plat/Block/LotPT SW SE SE</u>	\$ <u>69,295.36</u>	\$ <u>69,295.36</u>
2. _____	<u>Unplatted 55</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>69,295.36</u></u>	\$ <u><u>69,295.36</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 Healthcare of Olney

0050757

Report Period Beginning:

01/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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 Healthcare of Olney

0050757

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	20,000 Watt Generator		2010	8,067		5			8,067	9
10	Upgrade Existing Fire Alarm System		2010	16,191	1,619	10	1,619		11,064	10
11	Fire Alarm Panel & Fire doors		2011	20,209	1,954	10	1,954		10,863	11
12	A/C System improvemetns & New A/C units		2011	9,134	890	15	890		7,586	12
13	Signs		2012	7,427	743	10	743		3,095	13
14	AC Unit Replacement		2013	5,592	559	10	559		2,143	14
15	Toilets, Tubs, Lavatories, BR Fixtures - ARCH Unit		2013	5,259	263	20	263		1,052	15
16	Kitchen Cabinets, Countertops - ARCH Unit		2013	5,523	368	15	368		1,473	16
17	Door ARCH unit		2013	10,320	688	15	688		2,752	17
18	Call System ARCH Unit		2013	1,026	103	10	103		411	18
19	Flooring ARCH Unit		2013	10,671	2,134	5	2,134		4,341	19
20	Curtains, Drapes, Blinds - ARCH Unit		2013	2,578	516	5	516		2,063	20
21	Pendent Sprinklers		2013	1,290	86	15	86		344	21
22	GE Door Alarm Keypad - ARCH Unit		2013	1,074	107	10	107		429	22
23	Dining/Bathroom Flooring - ARCH Unit		2013	4,255	426	10	426		1,703	23
24	HTG & AC for Shower Room - ARCH Unit		2013	682	136	10	136		545	24
25	Fireplace		2013	1,499	150	5	150		575	25
26	Tear out old walls & replace - ARCH Unit		2013	157,405	7,870	10	7,870		31,481	26
27	4 Frigidaire Heat/Cool Units		2014	2,503	250	10	250		688	27
28	Replace water heater		2014	1,436	144	10	144		324	28
29	Schrey System		2014	1,792	179	10	179		403	29
30	CTS ran phone & data cable		2014	878	88	10	88		198	30
31	Redo all kitchen plumbing		2014	7,222	722	10	722		1,745	31
32	Frigidaire heat/cool unit		2014	1,259	252	5	252		609	32
33	Whisper Grove Hall - prep/paint/floor		2015	8,331	833	10	833		1,111	33
34	Read's Inc. - AC/Heat Unit		2015	5,806	1,161	5	1,161		2,225	34
35	Hardwood Flooring & Paint - A hall		2016	3,582	30	10	30		30	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney

0050757

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	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	Related Party Allocation - Bridgemark Healthcare LLC								63
64	2011	9,470		20	501	501	2,735	64	
65	2012	107		5	21	21	93	65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 310,588	\$ 22,271		\$ 22,793	\$ 522	\$ 100,148	70

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	\$ 130,927	\$ 11,690	\$ 14,767	\$ 3,077	3-15	\$ 53,967	71
72	Current Year Purchases	19,467	893	921	28	3-15	921	72
73	Fully Depreciated Assets	33,476					33,476	73
74								74
75	TOTALS	\$ 183,870	\$ 12,583	\$ 15,688	\$ 3,105		\$ 88,364	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Ford E-450	2010	\$ 3,407	\$	\$	\$	4	\$ 3,407	76
77	Related Party Allocation - Bridgemark			927				4	927	77
78										78
79										79
80	TOTALS			\$ 4,334	\$	\$	\$		\$ 4,334	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)	\$ 498,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,854	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,481	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,627	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 192,846	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 Olney

0050757

Report Period Beginning: 01/01/16

Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CR Aviv, LLC

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

If NO, see instructions. 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		\$ 724,372			3
4	Additions							4
5	Related Party Allocations				8,477			5
6	Storage Rental				1,282			6
7	TOTAL		118		\$ 734,131			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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

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: \$ 1,921 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		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				174,415		174,415	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					48,669		48,669	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3				650,869			650,869	13
14	TOTAL			\$		\$ 650,869	\$ 223,084		\$ 873,953	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

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	\$ 578	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>119,246</u>)	1,456,998		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	823		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	130,494		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,588,893	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	294,933		15
16	Equipment, at Historical Cost	146,422		16
17	Accumulated Depreciation (book methods)	(163,649)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	60,769		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 338,475	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,927,368	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,289,032	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,740		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,545		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,786		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>	5,205,531		36
37	<u>Accrued Provider Assessments</u>	21,822		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,659,456	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,659,456	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,732,088)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,927,368	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,051,468)	1
2	Restatements (describe):		2
3	Prior Year Adjustments for Workers Comp Audit	(70,456)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,121,924)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(610,164)	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)	\$ (610,164)	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)	\$ (4,732,088)	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	\$ 4,535,466	1
2	Discounts and Allowances for all Levels	(63,347)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,472,119	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	140,462	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 140,462	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	383	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)	\$ 383	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	4,115	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,115	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,617,079	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	705,920	31
32	Health Care	1,319,003	32
33	General Administration	945,115	33
B. Capital Expense			
34	Ownership	1,195,240	34
C. Ancillary Expense			
35	Special Cost Centers	873,953	35
36	Provider Participation Fee	188,012	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,227,243	40
41	Income before Income Taxes (line 30 minus line 40)**	(610,164)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (610,164)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,860,025	44
45	Private Pay - Net Inpatient Revenue	454,935	45
46	Medicare - Net Inpatient Revenue	1,894,919	46
47	Other-(specify) <u>Insurance</u>	258,904	47
48	Other-(specify) <u>Hospice</u>	3,336	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,472,119	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney

0050757

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	2,079	2,162	\$ 69,120	\$ 31.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,583	12,569	301,763	24.01	3
4	Licensed Practical Nurses	10,478	11,411	222,007	19.46	4
5	CNAs & Orderlies	39,881	42,241	496,852	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	283	314	4,954	15.78	8
9	Activity Director					9
10	Activity Assistants	1,490	1,648	20,453	12.41	10
11	Social Service Workers	1,623	1,840	29,674	16.13	11
12	Dietician					12
13	Food Service Supervisor	1,269	1,354	18,664	13.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,887	13,300	126,310	9.50	15
16	Dishwashers					16
17	Maintenance Workers	1,723	1,861	33,879	18.20	17
18	Housekeepers	9,868	10,502	111,288	10.60	18
19	Laundry	3,155	3,316	27,855	8.40	19
20	Administrator	1,976	2,134	74,679	34.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,950	2,187	40,433	18.49	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	1,130	1,130	13,842	12.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,375	107,969	\$ 1,591,773 *	\$ 14.74	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	\$ 7,417	1,3	35
36	Medical Director	12,000	9,3	36
37	Medical Records Consultant	2,164	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,491	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	4,742	11,3	44
45	Social Service Consultant	2,512	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 32,326		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 Healthcare of Olney# 0050757Report Period Beginning: 01/01/16Ending: 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? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,474 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 188,012
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? Yes Indicate the amount. \$ 383
- (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. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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 Olney
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

Description		
16A	Nursing Equipment	1,155
16B	Related Party Allocation - Bridgemark Healthcare	766
		<u>1,921</u>

Helia Healthcare of Olney
Attachment to Schedule XVII E
Other Revenue
12/31/2016

Description		
16A	Flu Shots	95
16B	Medical Records	521
16C	Miscellaneous Income	3,391
16D	Gain on disposal of asset	108
		<u>4,115</u>