FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0049775

Facility Name: Helia HC of Benton

Address: 1310 Mark Franklin Louis St (Number) Benton (City) 62896 (Zip Code)

County: Franklin

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

HFS ID Number:

Date of Initial License for Current Owners: 08/15/2008

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	83	Skilled (SNF)	83	30,378	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,378	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,904	6,646	6,799	27,349	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,904	6,646	6,799	27,349	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.03%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 8/15/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 6,533

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	90,418	21,249	380,100	491,767		491,767		491,767			1
2	Food Purchase		68,626		68,626		68,626	(343)	68,283			2
3	Housekeeping	128,041	30,228		158,269		158,269		158,269			3
4	Laundry	18,217	17,957	161,497	197,671		197,671		197,671			4
5	Heat and Other Utilities			96,153	96,153		96,153	(2,930)	93,223			5
6	Maintenance	33,381	24,420	30,825	88,626		88,626	16,523	105,149			6
7	Other (specify):*											7
8	TOTAL General Services	270,057	162,480	668,575	1,101,112		1,101,112	13,250	1,114,362			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,240,978	76,883	4,518	1,322,379		1,322,379	9,063	1,331,442			10
10a	Therapy		1,345		1,345		1,345		1,345			10a
11	Activities	32,331	14,526	1,635	48,492		48,492	(930)	47,562			11
12	Social Services	33,063	149	1,585	34,797		34,797		34,797			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,306,372	92,903	19,738	1,419,013		1,419,013	8,133	1,427,146			16
	C. General Administration											
17	Administrative	78,660		256,524	335,184		335,184	(223,314)	111,870			17
18	Directors Fees											18
19	Professional Services			21,269	21,269		21,269	10,114	31,383			19
20	Dues, Fees, Subscriptions & Promotions			68,842	68,842		68,842	(56,729)	12,113			20
21	Clerical & General Office Expenses	43,568	20,774	37,176	101,518		101,518	179,452	280,970			21
22	Employee Benefits & Payroll Taxes			344,888	344,888		344,888	39,401	384,289			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,500	1,500		1,500	3,443	4,943			24
25	Other Admin. Staff Transportation			9,524	9,524		9,524	11,122	20,646			25
26	Insurance-Prop.Liab.Malpractice			18,828	18,828		18,828	1,589	20,417			26
27	Other (specify):*											27
28	TOTAL General Administration	122,228	20,774	758,551	901,553		901,553	(34,922)	866,631			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,698,657	276,157	1,446,864	3,421,678		3,421,678	(13,539)	3,408,139			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION 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 HC of Benton #0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,253	25,253		25,253	16,328	41,581			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,011	32,011		32,011	11,913	43,924			32
33	Real Estate Taxes			24,000	24,000		24,000	3,112	27,112			33
34	Rent-Facility & Grounds			302,950	302,950		302,950	(284,524)	18,426			34
35	Rent-Equipment & Vehicles			81,898	81,898		81,898	(54,603)	27,295			35
36	Other (specify):*											36
37	**TOTAL Ownership**			466,112	466,112		466,112	(307,774)	158,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		217,246	673,451	890,697		890,697		890,697			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,278	226,278		226,278		226,278			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		217,246	899,729	1,116,975		1,116,975		1,116,975			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,698,657	493,403	2,812,705	5,004,765		5,004,765	(321,313)	4,683,452			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(930)	11		4
5	Telephone, TV & Radio in Resident Rooms	(5,098)	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	(838)	30		9
10	Interest and Other Investment Income	(397)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(343)	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	(300)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,654)	21		19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(125)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(43,221)	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	(15,846)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,852)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(250,461)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (250,461)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (321,313)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Helia HC of Benton

ID# 0049775

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (10,361)	20	1
2	Eliminate Lobbying & PAC Dues	(1,227)	20	2
3	Eliminate 2014 IDPH License Fee	(1,990)	20	3
4	Eliminate Out-Of-Period Legal Fees	(2,268)	19	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**	(15,846)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia HC of Benton # 0049775 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(343)	0	0	0	0	0	0	0	0	0	0	(343)	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	(5,098)	1,812	356	0	0	0	0	0	0	0	0	(2,930)	5
6	Maintenance	0	16,523	0	0	0	0	0	0	0	0	0	16,523	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,441)	18,335	356	0	0	0	0	0	0	0	0	13,250	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	9,063	0	0	0	0	0	0	0	0	9,063	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(930)	0	0	0	0	0	0	0	0	0	0	(930)	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**	(930)	0	9,063	0	0	0	0	0	0	0	0	8,133	16
	C. General Administration													
17	Administrative	0	0	(223,314)	0	0	0	0	0	0	0	0	(223,314)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,393)	784	11,723	0	0	0	0	0	0	0	0	10,114	19
20	Fees, Subscriptions & Promotions	(57,099)	0	370	0	0	0	0	0	0	0	0	(56,729)	20
21	Clerical & General Office Expenses	(3,754)	1,221	181,985	0	0	0	0	0	0	0	0	179,452	21
22	Employee Benefits & Payroll Taxes	0	7,932	31,469	0	0	0	0	0	0	0	0	39,401	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,443	0	0	0	0	0	0	0	0	3,443	24
25	Other Admin. Staff Transportation	0	5,236	5,886	0	0	0	0	0	0	0	0	11,122	25
26	Insurance-Prop.Liab.Malpractice	0	287	1,302	0	0	0	0	0	0	0	0	1,589	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(63,246)	15,460	12,864	0	0	0	0	0	0	0	0	(34,922)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(69,617)	33,795	22,283	0	0	0	0	0	0	0	0	(13,539)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia HC of Benton # 0049775 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	(838)	1,733	15,433	0	0	0	0	0	0	0	0	16,328	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(397)	8,792	3,518	0	0	0	0	0	0	0	0	11,913	32
33	Real Estate Taxes	0	3,000	112	0	0	0	0	0	0	0	0	3,112	33
34	Rent-Facility & Grounds	0	1,650	(286,174)	0	0	0	0	0	0	0	0	(284,524)	34
35	Rent-Equipment & Vehicles	0	0	(54,603)	0	0	0	0	0	0	0	0	(54,603)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,235)	15,175	(321,714)	0	0	0	0	0	0	0	0	(307,774)	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)**	(70,852)	48,970	(299,431)	0	0	0	0	0	0	0	0	(321,313)	45

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100%	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Carbondale	Carbondale, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Helia Healthcare Services	100.00%	$ 1,812	$ 1,812	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	19,523	16,523	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	784	784	3
4	V	21	Clerical & General Office		Helia Healthcare Services	100.00%	1,221	1,221	4
5	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	7,932	7,932	5
6	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	5,236	5,236	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	287	287	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	1,733	1,733	8
9	V	32	Interest		Helia Healthcare Services	100.00%	8,792	8,792	9
10	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,000	3,000	10
11	V	34	Rent-Facility & Grounds		Helia Healthcare Services	100.00%	1,650	1,650	11
12	V								12
13	V								13
14	Total			$ 3,000			$ 51,970	$ * 48,970	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 356	$ 356	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	9,063	9,063	16
17	V	17	Administrative	256,524	Bridgemark Healthcare, LLC	100.00%	33,210	(223,314)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	11,723	11,723	18
19	V	20	Dues,Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	370	370	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	181,677	181,677	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	31,469	31,469	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,443	3,443	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,886	5,886	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,302	1,302	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,640	4,640	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	112	112	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	10,621	10,621	27
28	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	297	297	28
29	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	3,224	3,224	29
30	V								30
31	V	21	Clerical & General Office Expenses		BM Properties I - Benton		167	167	31
32	V	30	Depreciation		BM Properties I - Benton		8,241	8,241	32
33	V	34	Rent - Facility & Grounds	302,950	BM Properties I - Benton		5,000	(297,950)	33
34	V	21	Clerical & General Office Expenses		Bridgemark Medical Supply	100.00%	141	141	34
35	V	30	Depreciation		Bridgemark Medical Supply	100.00%	2,552	2,552	35
36	V	32	Interest		Bridgemark Medical Supply	100.00%	294	294	36
37	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	1,155	1,155	37
38	V	35	Equipment Rental	54,900	Bridgemark Medical Supply	100.00%		(54,900)	38
39	Total			$ 614,374			$ 314,943	$ * (299,431)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Helia Southbelt Healthcare	Belleville, IL				2
3			Hillside Rehab & Care Center	Yorkville, IL				3
4			Helia Healthcare of Rolla	Rolla, MO				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	303,415	4.93	9.87	Distribution	$ 33,210	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	$ 33,210		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' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Bridgemark Healthcare, LLC
Street Address: 11970 Borman Drive, Suite 100
City / State / Zip Code: St. Louis, MO 63146
Phone Number: ((314)431-0511
Fax Number: ((314)754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	277,215	11	$ 3,605	$	27,349	$ 356	1
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	27,349	9,063	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625		27,349	33,210	3
4	19	Professional Fees	Resident Days	277,215	11	118,827		27,349	11,723	4
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754		27,349	370	5
6	21	Salaries-Other	Resident Days	277,215	11	1,345,667	1,345,667	27,349	132,758	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853		27,349	48,919	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977		27,349	31,469	8
9	24	Seminars	Resident Days	277,215	11	34,902		27,349	3,443	9
10	25	Admin Staff Travel	Resident Days	277,215	11	59,659		27,349	5,886	10
11	26	Insurance	Resident Days	277,215	11	13,196		27,349	1,302	11
12	30	Depreciation	Resident Days	277,215	11	47,028		27,349	4,640	12
13	33	Real Estate Taxes	Resident Days	277,215	11	1,133		27,349	112	13
14	34	Building Rent	Resident Days	277,215	11	103,521		27,349	10,213	14
15	34	Rental-Storage Unit	Resident Days	277,215	11	4,139		27,349	408	15
16	35	Equipment Rental	Resident Days	277,215	11	3,007		27,349	297	16
17	32	Interest	Resident Days	277,215	11	32,681		27,349	3,224	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,014,441	$ 1,437,534		$ 297,393	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Helia Healthcare Services
Street Address: 308 Mcleansboro Street
City / State / Zip Code: Benton, IL 62812
Phone Number: ((618)435-3304
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Revenue	12,000	4	$ 7,249	$	3,000	$ 1,812	1
2	6	Mainenance	Revenue	12,000	4	78,091	75,311	3,000	19,523	2
3	19	Professional Services	Revenue	12,000	4	3,135		3,000	784	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	4,882		3,000	1,221	4
5	22	Payroll Taxes & Emp. Ben.	Revenue	12,000	4	31,729		3,000	7,932	5
6	25	Other Admin Transportation	Revenue	12,000	4	20,942		3,000	5,236	6
7	26	Insurance	Revenue	12,000	4	1,148		3,000	287	7
8	30	Depreciation	Revenue	12,000	4	6,932		3,000	1,733	8
9	32	Interest	Revenue	12,000	4	35,169		3,000	8,792	9
10	33	Real Estate Taxes	Revenue	12,000	4	12,000		3,000	3,000	10
11	34	Rent	Revenue	12,000	4	6,600		3,000	1,650	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					$ 207,877	$ 75,311		$ 51,970	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Bridgemark Medical Supply
Street Address:
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & General Office	Revenue	336,537	5	$ 865	$	54,900	$ 141	1
2	30	Depreciation	Revenue	336,537	5	15,646		54,900	2,552	2
3	32	Interest	Revenue	336,537	5	1,800		54,900	294	3
4	34	Rent - Facility & Grounds	Revenue	336,537	5	7,080		54,900	1,155	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					$ 25,391	$		$ 4,142	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	32,011	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 32,011	9
	B. Non-Facility Related*											
10	Interest Income		X								(397)	10
11	Related Party Allocation - Helia Healthcare										8,792	11
12	Related Party Allocation - Bridgemark Healthcare										3,224	12
13	Related Party Allocation - Bridgemark Medical Supply										294	13
14	TOTAL Non-Facility Related						$	$			$ 11,913	14
15	TOTALS (line 9+line14)						$	$			$ 43,924	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia HC of Benton # 0049775 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 81,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (81,000)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 105,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 24,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010	See note on	11
	2011	Tax Statement	12

$24,000 Line 7: Estimate of property taxes when the county separates the parcel to Bridgemark
112 Allocation from Bridgemark Healthcare
3,000 Allocation from Helia Healthcare
$27,112 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia HC of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

TELEPHONE (314)431-0511 FAX #: (314)754-9176

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	The parcel for this property has not been split out by the County to		$	$
2.	date. When the facility was owned by the Hospital, it was not assessed		$	$
3.	for real estate taxes. An estimate for real estate taxes has been accrued		$	$
4.	by the provider.		$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Pary Allocation Helia Healthcare			$ 1,250	1
2					2
3	TOTALS			$ 1,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Helia Healthcare Allocation		2006		$ 7,450	$	25	$ 372	$ 372	$ 2,546	4
5	83		2008		134,098		30	4,470	4,470	19,742	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		319	9
10	Exterior Sign			2009	5,265	527	10	527		2,018	10
11	Landscaping			2009	4,135	414	10	414		1,551	11
12	Wallcovering for hallways & Entranceway, doors, shower remodel			2009	11,252	750	15	750		2,500	12
13	Carpet			2009	1,170	234	5	234		780	13
14	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		554	14
15	New Pipes, Install Eye Wash			2010	2,215	89	25	89		229	15
16	AC, fans, dehumidifier			2010	1,609	161	10	161		402	16
17	Outside single door & frame			2010	4,168	278	15	278		625	17
18	Shower Room - Tile, shower heads, electrical work, fixtures, paint			2011	3,860	257	15	257		407	18
19	Dinette/Common area remodel - doors, windows, counters, cabinetry										19
20	(cont.) flooring, electrical, plywood, paint			2011	13,693	913	15	913		1,446	20
21	Back-Up Generator			2011	12,864	429	20	643	214	858	21
22	Sprinkler System			2012	97,800	3,912	25	3,912		3,912	22
23	Fire Doors			2012	9,943	552	15	552		552	23
24	Oxygen Shed			2012	1,941	81	10	81		81	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

*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' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation - Helia Healthcare		$	$		$	$	$	37
38	Water & Sewer Pipe Installation	2006	475		20	24	24	153	38
39	Plumbing & Heating Installation	2006	569		20	29	29	183	39
40	A/C Unit - 4 Ton	2007	1,370		10	137	137	776	40
41									41
42	Related Party Allocation - Bridgemark Healthcare LLC								42
43	New Office Build-Out	2011	13,399		20	709	709	1,031	43
44	Conference Rm Chair Rail & Paint	2012	152		5	10	10	10	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 331,205	$ 8,848		$ 14,813	$ 5,965	$ 40,675	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 156,989	$ 6,552	$ 17,061	$ 10,509	3-5	$ 72,133	71
72	Current Year Purchases	23,709	1,567	1,893	326	5	1,893	72
73	Fully Depreciated Assets	42,189					42,189	73
74								74
75	TOTALS	$ 222,887	$ 8,119	$ 18,954	$ 10,835		$ 116,215	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party Allocation-Bridgemark		2005	$ 1,311	$	$ 328	$ 328	5	$ 1,174	76
77	Related Party Allocation-Helia		2006	1,678		281	281	5	1,373	77
78	Facility	Bus	2011	28,821	8,286	7,205	(1,081)	4	12,609	78
79										79
80	TOTALS			$ 31,810	$ 8,286	$ 7,814	$ (472)		$ 15,156	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)	$ 587,152	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,253	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 41,581	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,328	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 172,046	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' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 27,295 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' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				1,345		1,345	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				159,203		159,203	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab, X-Ray, Therapy	39, 3				673,451			673,451	12
13	Other (specify): Wound Care Oxygen, Enterals	39, 2					58,043		58,043	13
14	TOTAL			$		$ 673,451	$ 218,591		$ 892,042	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' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 920	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,220,249		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,331		7
8	Accounts Receivable (owners or related parties)	2,292,635		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,516,135	$	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	173,691		15
16	Equipment, at Historical Cost	148,312		16
17	Accumulated Depreciation (book methods)	(95,076)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 226,927	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,743,062	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 847,587	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,067		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,414		31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	57,926		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,140,994	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	123,729		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)**	$ 123,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,264,723	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,478,339	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,743,062	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,278,431	1
2	Restatements (describe):		2
3	**Prior Year Depreciation Adjustment**	839	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,279,270	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,069	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)**	$ 199,069	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)**	$ 2,478,339	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,099,482	1
2	Discounts and Allowances for all Levels	(76,100)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,023,382	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	176,947	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 176,947	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	930	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)**	$ 930	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	397	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 447	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Part B Vaccines	2,128	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,128	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,203,834	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,101,112	31
32	Health Care	1,419,013	32
33	General Administration	901,553	33
	B. Capital Expense		
34	Ownership	466,112	34
	C. Ancillary Expense		
35	Special Cost Centers	890,697	35
36	Provider Participation Fee	226,278	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,004,765	40
41	**Income before Income Taxes (line 30 minus line 40)****	199,069	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 199,069	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,597,931	44
45	Private Pay - Net Inpatient Revenue	686,103	45
46	Medicare - Net Inpatient Revenue	2,650,130	46
47	Other-(specify) Insurance	89,218	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,023,382	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' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,030	2,114	$ 71,182	$ 33.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,333	7,941	161,206	20.30	3
4	Licensed Practical Nurses	18,825	20,426	344,690	16.88	4
5	CNAs & Orderlies	62,779	67,408	659,985	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,924	3,137	32,331	10.31	10
11	Social Service Workers	1,929	2,112	33,063	15.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,153	9,895	90,418	9.14	15
16	Dishwashers					16
17	Maintenance Workers	2,180	2,379	33,381	14.03	17
18	Housekeepers	11,736	12,425	128,041	10.31	18
19	Laundry	1,979	1,993	18,217	9.14	19
20	Administrator	2,085	2,305	78,660	34.13	20
21	Assistant Administrator					21
22	Other Administrative	1,080	1,116	12,130	10.87	22
23	Office Manager	1,648	1,888	31,438	16.65	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	205	235	3,915	16.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,886	135,374	$ 1,698,657 *	$ 12.55	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		1,830	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,688	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		1,635	11,3	44
45	Social Service Consultant		1,585	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,738		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra McCoy	Administrator	0	$ 17,305
Steven Johnson	Administrator	0	61,355
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,660

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 256,524
TOTAL (agree to Schedule V, line 17, col. 3)	$ 256,524
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,025
Ceridian	Payroll Processing	12,119
Kramer & Frank	Collections	125
Personnel Planners, Inc.	Unemployment Consultant	1,828
Polisinelli Shughart PC	Legal Fees	904
Polisinelli Shughart PC	Out-of-period legal fees	2,268
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,269

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,607
Unemployment Compensation Insurance	105,217
FICA Taxes	129,029
Employee Health Insurance	28,144
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,537
Employee Benefits	5,311
Uniforms	1,008
Employee Insurance	3,035
Related Party Allocation-Bridgemark	31,469
Related Party Allocation-Helia	7,932
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,289

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,851
Health Care Worker Background Check	
(Indicate # of checks performed)	1,806
Patient Background Checks	
Dues & Subscriptions	1,877
Late Fees	356
Miscellaneous Licenses & Fees	863
Related Party Allocation-Bridgemark	370
Advertising	43,221
Less: Public Relations Expense	( )
Non-allowable advertising	(43,221)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,113

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	430
Seminar Expense	1,070
Related Pary Allocation-Bridgemark	3,443
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,943

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton # 0049775 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Benton **#** 0049775 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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 $1,678**

(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. $ **8,971** 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. $ **226,278**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** 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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2012

	Description	
16A	Nursing Equipment Rental	$ 24,703
16B	Dietary Equipment Rental	191
16C	Copier Lease	2,104
16D	Related Party Allocation - Bridgemark	297
		$ 27,295