

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0050757</u></p> <p>Facility Name: <u>Richland Care & Rehab</u></p> <p>Address: <u>410 E Mack</u> <u>Olney</u> <u>62450</u> <small>Number City Zip Code</small></p> <p>County: <u>Richland</u></p> <p>Telephone Number: <u>(618) 395-7421</u> Fax # <u>(618) 395-8210</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>4/30/1998</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618)465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p align="center"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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. </p> <p align="center"> Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. </p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u> </td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u>							
Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Richland Care & Rehab

0050757 Report Period Beginning: 01/01/12 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	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,527	2,165	2,084	25,776	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,527	2,165	2,084	25,776	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.68%

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 1,845

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	152,035	19,209	5,304	176,548		176,548		176,548	1	
2	Food Purchase		145,825		145,825		145,825	(61)	145,764	2	
3	Housekeeping	62,568	26,047		88,615		88,615		88,615	3	
4	Laundry	44,682	16,561		61,243		61,243		61,243	4	
5	Heat and Other Utilities			97,252	97,252		97,252	(10,593)	86,659	5	
6	Maintenance	14,757	5,784	44,020	64,561		64,561		64,561	6	
7	Other (specify):*									7	
8	TOTAL General Services	274,042	213,426	146,576	634,044		634,044	(10,654)	623,390	8	
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000	9	
10	Nursing and Medical Records	1,006,021	76,254	5,808	1,088,083		1,088,083	8,542	1,096,625	10	
10a	Therapy		1,424	100	1,524		1,524		1,524	10a	
11	Activities	33,941	10,955	7,777	52,673		52,673	(603)	52,070	11	
12	Social Services	36,898	139	3,340	40,377		40,377		40,377	12	
13	CNA Training									13	
14	Program Transportation			10,485	10,485		10,485		10,485	14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,076,860	88,772	39,510	1,205,142		1,205,142	7,939	1,213,081	16	
	C. General Administration										
17	Administrative	75,341		181,700	257,041		257,041	(150,400)	106,641	17	
18	Directors Fees									18	
19	Professional Services			17,905	17,905		17,905	11,049	28,954	19	
20	Dues, Fees, Subscriptions & Promotions			76,002	76,002		76,002	(54,218)	21,784	20	
21	Clerical & General Office Expenses	36,314	10,588	97,097	143,999		143,999	105,457	249,456	21	
22	Employee Benefits & Payroll Taxes			297,554	297,554		297,554	29,659	327,213	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			5,247	5,247		5,247	3,245	8,492	24	
25	Other Admin. Staff Transportation			14,820	14,820		14,820	5,547	20,367	25	
26	Insurance-Prop.Liab.Malpractice			17,898	17,898		17,898	1,227	19,125	26	
27	Other (specify):*									27	
28	TOTAL General Administration	111,655	10,588	708,223	830,466		830,466	(48,434)	782,032	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,462,557	312,786	894,309	2,669,652		2,669,652	(51,149)	2,618,503	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 Richland Care & Rehab

#0050757

Report Period Beginning:

01/01/12

Ending:

12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,927	13,927		13,927	4,566	18,493			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			170,146	170,146		170,146	2,966	173,112			32
33	Real Estate Taxes			60,744	60,744		60,744	105	60,849			33
34	Rent-Facility & Grounds			644,694	644,694		644,694	10,011	654,705			34
35	Rent-Equipment & Vehicles			19,567	19,567		19,567	280	19,847			35
36	Other (specify):*											36
37	TOTAL Ownership			909,078	909,078		909,078	17,928	927,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,324	588,235	707,559		707,559		707,559			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,447	285,447		285,447		285,447			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		119,324	873,682	993,006		993,006		993,006			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,462,557	432,110	2,677,069	4,571,736		4,571,736	(33,221)	4,538,515			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 Richland Care & Rehab

0050757

Report Period Beginning: 01/01/12

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.)

		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	(603)	11		4
5	Telephone, TV & Radio in Resident Rooms	(10,928)	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	193	30		9
10	Interest and Other Investment Income	(73)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(61)	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	(775)	20		17
18	Fines and Penalties	(61,255)	21		18
19	Entertainment	(4,516)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(49,295)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,497)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,810)		\$	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	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)	98,589	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 98,589		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (33,221)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Richland Care & Rehab

ID# 0050757

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts & Flowers	\$ (2,752)	20	1
2	Eliminate Lobbying & PAC Dues	(1,745)	20	2
3				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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(4,497)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Richland Care & Rehab# 0050757

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	(61)	0	0	0	0	0	0	0	0	0	0	(61)	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	(10,928)	335	0	0	0	0	0	0	0	0	0	(10,593)	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	(10,989)	335	0	0	0	0	0	0	0	0	0	(10,654)	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	8,542	0	0	0	0	0	0	0	0	0	8,542	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(603)	0	0	0	0	0	0	0	0	0	0	(603)	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	(603)	8,542	0	0	0	0	0	0	0	0	0	7,939	16
	C. General Administration													
17	Administrative	0	(150,400)	0	0	0	0	0	0	0	0	0	(150,400)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,049	0	0	0	0	0	0	0	0	0	11,049	19
20	Fees, Subscriptions & Promotions	(54,567)	349	0	0	0	0	0	0	0	0	0	(54,218)	20
21	Clerical & General Office Expenses	(65,771)	171,228	0	0	0	0	0	0	0	0	0	105,457	21
22	Employee Benefits & Payroll Taxes	0	29,659	0	0	0	0	0	0	0	0	0	29,659	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,245	0	0	0	0	0	0	0	0	0	3,245	24
25	Other Admin. Staff Transportation	0	5,547	0	0	0	0	0	0	0	0	0	5,547	25
26	Insurance-Prop.Liab.Malpractice	0	1,227	0	0	0	0	0	0	0	0	0	1,227	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(120,338)	71,904	0	0	0	0	0	0	0	0	0	(48,434)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(131,930)	80,781	0	0	0	0	0	0	0	0	0	(51,149)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12 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	193	4,373	0	0	0	0	0	0	0	0	0	4,566	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(73)	3,039	0	0	0	0	0	0	0	0	0	2,966	32
33	Real Estate Taxes	0	105	0	0	0	0	0	0	0	0	0	105	33
34	Rent-Facility & Grounds	0	0	10,011	0	0	0	0	0	0	0	0	10,011	34
35	Rent-Equipment & Vehicles	0	0	280	0	0	0	0	0	0	0	0	280	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	120	7,517	10,291	0	0	0	0	0	0	0	0	17,928	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)	(131,810)	88,298	10,291	0	0	0	0	0	0	0	0	(33,221)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100%	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Energy	Energy, 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. 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%	\$ 335	\$ 335	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	8,542	8,542	2
3	V	17 Administrative	181,700	Bridgemark Healthcare, LLC	100.00%	31,300	(150,400)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	11,049	11,049	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	349	349	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	171,228	171,228	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	29,659	29,659	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,245	3,245	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,547	5,547	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,227	1,227	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	4,373	4,373	11
12	V	32 Interest		Bridgemark Healthcare, LLC	100.00%	3,039	3,039	12
13	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	105	105	13
14	Total		\$ 181,700			\$ 269,998	\$ * 88,298	14

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

SEE ACCOUNTANTS' COMPILATION 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	34 Rental - Storage Unit	\$	Bridgemark Healthcare, LLC	100.00%	\$ 10,011	\$	10,011	15
16	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	280		280	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 10,291	\$ *	10,291	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12

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 Richland Care & Rehab # 0050757 Report Period Beginning: 01/01/12 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 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	305,325	5	9.30	Distribution	\$ 31,300	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	\$ 31,300		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 Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12

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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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Resident Days	277,215	11	\$ 3,605	\$ 25,776	\$ 335	1	
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	25,776	8,542	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625	25,776	31,300	3	
4	19	Professional Fees	Resident Days	277,215	11	118,827	25,776	11,049	4	
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754	25,776	349	5	
6	21	Salaries-Other	Resident Days	277,215	11	1,345,667	1,345,667	25,776	125,123	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853	25,776	46,105	7	
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977	25,776	29,659	8	
9	24	Travel & Seminar	Resident Days	277,215	11	34,902	25,776	3,245	9	
10	25	Other Admin Transp	Resident Days	277,215	11	59,659	25,776	5,547	10	
11	26	Insurance	Resident Days	277,215	11	13,196	25,776	1,227	11	
12	30	Depreciation	Resident Days	277,215	11	47,028	25,776	4,373	12	
13	32	Interest	Resident Days	277,215	11	32,681	25,776	3,039	13	
14	33	Real Estate Taxes	Resident Days	277,215	11	1,133	25,776	105	14	
15	34	Building Rent	Resident Days	277,215	11	103,521	25,776	9,626	15	
16	34	Rental-Storage Unit	Resident Days	277,215	11	4,139	25,776	385	16	
17	35	Equipment Rental	Resident Days	277,215	11	3,007	25,776	280	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,014,441	\$ 1,437,534	\$ 280,289	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Richland Care & Rehab

0050757

Report Period Beginning:

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Ending:

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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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	170,146					
7																
8																
9	TOTAL Facility Related							\$	\$		\$	170,146				
	B. Non-Facility Related*															
10	Interest Income		X								(73)					
11																
12	Related Party Allocation - Bridgemark										3,039					
13																
14	TOTAL Non-Facility Related							\$	\$		\$	2,966				
15	TOTALS (line 9+line14)							\$	\$		\$	173,112				

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.)

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.		\$		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.)		\$	60,744			2
3. Under or (over) accrual (line 2 minus line 1).		\$	60,744			3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$				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.		\$	60,744			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007	<u>47,925</u>	8	FOR BHF USE ONLY	
		2008	<u>53,404</u>	9	13	FROM R. E. TAX STATEMENT FOR 2011 \$
		2009	<u>57,388</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
		2010	<u>59,031</u>	11	15	LESS REFUND FROM LINE 6 \$
		2011	<u>58,974</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
\$60,744 Line 7						
105 Bridgemark Healthcare Allocation						
\$60,849 Total Schedule V, Line 33						

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 Richland Care & Rehab COUNTY Richland
 FACILITY IDPH LICENSE NUMBER 0050757
 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)	(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/Lot PT SW SE SE</u>	\$ <u>58,974.40</u>	\$ <u>58,974.40</u>
2. _____	<u>Unplatted 55</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>58,974.40</u></u>	\$ <u><u>58,974.40</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 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 Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12 Ending:

12/31/12

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12

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	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	20,000 Watt Generator		2010	8,067	1,613	5	1,613		4,706
10	Upgrade Existing Fire Alarm System		2010	16,191	1,619	10	1,619		4,587
11	Fire Alarm Panel & Fire Doors		2011	20,209	1,954	10	1,954		3,048
12	A/C System Improvements & New A/C Units		2011	9,134	1,287	15	1,509	222	2,168
13	Data & phone cabling		2012	1,169	117	10	117		117
14	Signs		2012	7,427	124	10	124		124
15									
16									
17									
18									
19	Related Party Allocation - Bridgemark								
20	New Office Build-Out		2011	12,628		20	669	669	972
21	Conference Room Chair Rail & Paint		2012	143		5	9	9	9
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12

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	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				
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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)	\$	74,968	\$	6,714	\$	7,614	\$	900	\$	15,731	70

SEE ACCOUNTANTS' COMPILATION 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	\$ 41,462	\$ 4,146	\$ 7,196	\$ 3,050	3-15	\$ 13,745	71
72	Current Year Purchases	54,210	2,215	2,522	307	3-15	2,522	72
73	Fully Depreciated Assets	182					182	73
74								74
75	TOTALS	\$ 95,854	\$ 6,361	\$ 9,718	\$ 3,357		\$ 16,449	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			\$ 1,236	\$	\$ 309	\$ 309	4	\$ 1,107	76
77	Facility	2002 Ford E-450	2010	3,407	852	852		4	2,484	77
78										78
79										79
80	TOTALS			\$ 4,643	\$ 852	\$ 1,161	\$ 309		\$ 3,591	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)	\$ 175,465	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,927	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,493	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,566	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 35,771	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	New Wing	\$ 178,006	92
93			93
94			94
95		\$ 178,006	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

Richland Care & Rehab

0050757

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Ending: 12/31/12

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		\$ 643,694			3
4	Additions							4
5	Related Party Allocation-Bridgemark				10,011			5
6	Storage Rental				1,000			6
7	TOTAL		118		\$ 654,705			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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 19,847

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 Richland Care & Rehab # 0050757 Report Period Beginning: 01/01/12 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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

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	10a,2	hrs				39		39	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				1,385		1,385	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				83,072		83,072	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound Care, Oxygen</u>	39,2					36,252		36,252	12
13	Other (specify): <u>Lab, X-Ray, Other</u>	39,3				588,235			588,235	13
14	TOTAL			\$		\$ 588,235	\$ 120,748		\$ 708,983	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

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,008	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>112,251</u>)	1,022,803		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,915		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,025,726	\$	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	55,445		15
16	Equipment, at Historical Cost	88,481		16
17	Accumulated Depreciation (book methods)	(26,694)		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): <u>Construction In Progress</u>	178,006		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 295,238	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,320,964	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 752,358	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,917		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,264		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Provider Assessments</u>	73,181		36
37	<u>Due To Bridgemark Healthcare</u>	2,513,015		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,443,735	\$	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)	\$ 3,443,735	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,122,771)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,320,964	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,396,706)	1
2	Restatements (describe):		2
3	Prior Year Depreciation Adjustment	(193)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,396,899)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(725,872)	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)	\$ (725,872)	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)	\$ (2,122,771)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,495,633	1
2	Discounts and Allowances for all Levels	(51,600)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,444,033	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	400,590	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 400,590	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	100	24
25	Interest and Other Investment Income***	73	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 173	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Machine Income</u>	603	28
28a	<u>Miscellaneous Income</u>	465	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,068	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,845,864	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	634,044	31
32	Health Care	1,205,142	32
33	General Administration	830,466	33
B. Capital Expense			
34	Ownership	909,078	34
C. Ancillary Expense			
35	Special Cost Centers	707,559	35
36	Provider Participation Fee	285,447	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,571,736	40
41	Income before Income Taxes (line 30 minus line 40)**	(725,872)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (725,872)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,336,183	44
45	Private Pay - Net Inpatient Revenue	189,667	45
46	Medicare - Net Inpatient Revenue	896,939	46
47	Other-(specify) <u>Insurance</u>	530	47
48	Other-(specify) <u>Hospice</u>	20,714	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,444,033	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 Richland Care & Rehab

0050757

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,279	2,439	\$ 57,988	\$ 23.78	1
2	Assistant Director of Nursing	2,326	2,561	42,194	16.48	2
3	Registered Nurses	6,575	6,977	139,105	19.94	3
4	Licensed Practical Nurses	17,594	18,508	319,637	17.27	4
5	CNAs & Orderlies	41,187	42,934	422,213	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,622	1,850	24,884	13.45	8
9	Activity Director					9
10	Activity Assistants	3,062	3,299	33,941	10.29	10
11	Social Service Workers	2,003	2,107	36,898	17.51	11
12	Dietician					12
13	Food Service Supervisor	1,753	1,935	29,767	15.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,197	13,053	122,268	9.37	15
16	Dishwashers					16
17	Maintenance Workers	1,118	1,204	14,757	12.26	17
18	Housekeepers	6,291	6,785	62,568	9.22	18
19	Laundry	5,012	5,200	44,682	8.59	19
20	Administrator	2,110	2,280	75,341	33.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,120	2,326	36,314	15.61	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,249	113,458	\$ 1,462,557 *	\$ 12.89	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	\$ 5,304	1,3	35
36	Medical Director	12,000	9,3	36
37	Medical Records Consultant	2,704	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,104	10,3	39
40	Physical Therapy Consultant	100	10a,3	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	7,777	11,3	44
45	Social Service Consultant	3,340	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 34,329		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' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Charles Schuette	Administrator	0	\$ 6,781	Workers' Compensation Insurance	\$ 65,041	IDPH License Fee	\$ 1,990	
Paula McKnight	Administrator	0	68,560	Unemployment Compensation Insurance	98,512	Advertising: Employee Recruitment	10,973	
				FICA Taxes	111,087	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	14,788	Patient Background Checks	2,918	
				Employee Meals		Dues & Subscriptions	2,495	
				Illinois Municipal Retirement Fund (IMRF)*		Late Fees	1,793	
				401(k) Match	1,587	Miscellaneous Licenses & Fees	1,266	
				Employee Benefits	6,364	Related Party Allocation-Bridgemark	349	
				Uniforms	175	Advertising	49,295	
						Less: Public Relations Expense ()		
				Related Party Allocation-Bridgemark	29,659	Non-allowable advertising ()	(49,295)	
						Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,341			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,784	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
Bridgemark Healthcare LLC-Management Fees			\$ 181,700					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 181,700					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C.J. Schlosser & Company, LLC	Accounting Services		\$ 4,025	Section N/A		\$	Out-of-State Travel	\$
Ceridian	Payroll Processing		11,178					
Personnel Planners, Inc.	Unemployment Consultant		2,702				In-State Travel	2,077
							Seminar Expense	3,170
							Related Pary Allocation-Bridgemark	3,245
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 17,905	TOTAL		\$	TOTAL	\$ 8,492

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	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 Richland Care & Rehab# 0050757

Report Period Beginning:

01/01/12

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 \$2,385
- (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. \$ 6,734 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 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. \$ 285,447
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? N/A
- (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. \$ 603
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Olney d/b/a Richland Care & Rehab
Attachment to Schedule XII B
Equipment Rentals
12/31/2012

<u>Description</u>		
16A	Nursing Equipment Rental	\$ 18,619
16B	Dietary Equipment Rental	948
16C	Related Party Allocation - Bridgemark	280
		<u>\$ 19,847</u>

Richland Rehab and Care Center
Attachment to Schedule XX G.
Seminar Detailed Description
12/31/2012

Name of Employee Attending	Location	Job Title	Date	Seminar Title	Seminar Sponsor	Seminar Cost	Travel Cost
Mary Kasting	St. Louis, MO	Alz Director	4/5/12	Train The Trainer	Alzheimer's Association	\$ 210	
Paula McKnight	St. Louis, MO	Administrator	4/17/12	Train The Trainer	Alzheimer's Association	\$ 210	\$ 80.00
Nan Dunn	N/A	Dietary	7/11/12	Dietary CEU	Association of Nutrition & Food	\$ 145	
Jennifer Workman	N/A	Social Services	12/4/12	Admin License	Continental Testing	\$ 261	
Jennifer Workman	Springfield, IL	Social Services	7/11/12	Workshop	Human Services	\$ 65	\$ 126.00
Mary Kasting	Salem, IL	Alz Director	6/5/12	Training	IL Pioneer Coalition	\$ 30	\$ 52.00
Paula McKnight	Springfield, IL	Administrator	9/5/12	Seminar	IL Pioneer Coalition	\$ 189	\$ 249.00
Peggy Lister	Springfield, IL	MDS Coord	9/14/12	MDS Training	IL Pioneer Coalition	\$ 550	\$ 413.00
Jennifer Workman	Springfield, IL	Social Services	11/6/12	Admin License	IHCA	\$ 595	\$ 253.00
			3/31/12	Long Term Care Nurse	Maitlan Warner	\$ 75	
Jennifer Workman	Olney, IL	Social Services	10/12/12	Training	Olney Central College	\$ 40	\$ 2.00
Lori Henson	Breese, IL	Activities	3/26/12	Activities Director Course	Outcome Services of IL	\$ 400	
Jennifer Workman	Breese, IL	Social Services	3/16/12	MDS Training	Outcome Services of IL	\$ 170	\$ 76.00
Mary McCollum		Dietary	9/11/12	Sanitation Class		\$ 60	
Scott Mitchell		Alz Director	7/10/12	Train The Trainer	Alzheimer's Association	\$ 170	
Lodging for temporary Administrator in Olney							\$ 725
Miscellaneous travel costs							\$ 101
Related Party Allocation - Bridgemark						\$ 3,245	
						<u>\$ 6,415</u>	<u>\$ 2,077</u>
							\$ 8,492