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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0048827

Facility Name: Helia Hlthcare of Belleville

Address: 40 North 64th Street (Number) Belleville (City) 62223 (Zip Code)

County: St Clair

Telephone Number: (618 **Fax #** (618) 397-8470

HFS ID Number:

Date of Initial License for Current Owners: 6/1/1996

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 1/01/13 to 12/31/13 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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 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	122	Skilled (SNF)	122	44,530	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	122	TOTALS	122	44,530	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	22,726	1,114	6,404	30,244	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,726	1,114	6,404	30,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.92%

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 12/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 3,650

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: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	164,439	19,892	12,501	196,832		196,832		196,832			1
2	Food Purchase		158,870		158,870		158,870	(1,602)	157,268			2
3	Housekeeping	114,684	34,400	802	149,886		149,886		149,886			3
4	Laundry	33,434	25,292		58,726		58,726		58,726			4
5	Heat and Other Utilities			114,510	114,510		114,510	250	114,760			5
6	Maintenance	62,876	13,577	110,243	186,696		186,696		186,696			6
7	Other (specify):*											7
8	TOTAL General Services	375,433	252,031	238,056	865,520		865,520	(1,352)	864,168			8
	B. Health Care and Programs											
9	Medical Director			34,800	34,800		34,800		34,800			9
10	Nursing and Medical Records	1,631,843	263,531	26,418	1,921,792		1,921,792	6,991	1,928,783			10
10a	Therapy	590,055	3,793		593,848		593,848		593,848			10a
11	Activities	61,759	11,702	8,896	82,357		82,357	(3,920)	78,437			11
12	Social Services	38,458	126	3,083	41,667		41,667		41,667			12
13	CNA Training											13
14	Program Transportation			13,170	13,170		13,170		13,170			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,322,115	279,152	86,367	2,687,634		2,687,634	3,071	2,690,705			16
	C. General Administration											
17	Administrative	61,511		396,300	457,811		457,811	(361,299)	96,512			17
18	Directors Fees											18
19	Professional Services			35,245	35,245		35,245	17,336	52,581			19
20	Dues, Fees, Subscriptions & Promotions			60,275	60,275		60,275	(34,268)	26,007			20
21	Clerical & General Office Expenses	74,789	16,402	76,283	167,474		167,474	212,007	379,481			21
22	Employee Benefits & Payroll Taxes			504,453	504,453		504,453	28,379	532,832			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,968	1,968		1,968	6,532	8,500			24
25	Other Admin. Staff Transportation			6,853	6,853		6,853	4,891	11,744			25
26	Insurance-Prop.Liab.Malpractice			38,784	38,784		38,784	2,798	41,582			26
27	Other (specify):*											27
28	TOTAL General Administration	136,300	16,402	1,120,161	1,272,863		1,272,863	(123,624)	1,149,239			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,833,848	547,585	1,444,584	4,826,017		4,826,017	(121,905)	4,704,112			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 Hlthcare of Belleville #0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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			40,182	40,182		40,182	16,931	57,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,159	21,159		21,159	(21,159)				32
33	Real Estate Taxes			64,302	64,302		64,302	43	64,345			33
34	Rent-Facility & Grounds			627,573	627,573		627,573	15,095	642,668			34
35	Rent-Equipment & Vehicles			275,450	275,450		275,450	(42,173)	233,277			35
36	Other (specify):* Gain or Loss on Disposal			1,313	1,313		1,313		1,313			36
37	TOTAL Ownership			1,029,979	1,029,979		1,029,979	(31,263)	998,716			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		373,740	615,515	989,255		989,255		989,255			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,821	229,821		229,821		229,821			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		373,740	845,336	1,219,076		1,219,076		1,219,076			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,833,848	921,325	3,319,899	7,075,072		7,075,072	(153,168)	6,921,904			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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	(3,920)	11		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	244	30		9
10	Interest and Other Investment Income	(21,159)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,602)	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	(550)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,594)	21		19
20	Contributions	(698)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,755)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,081)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,115)		$	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)	(87,053)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,053)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (153,168)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Hlthcare of Belleville

ID# 0048827

Report Period Beginning: 1/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (8,758)	20	1
2	Offset Medical Record Copy Revenue	(323)	10	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**	(9,081)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 **Report Period Beginning:** 1/01/13 **Ending:** 12/31/13

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	(1,602)	0	0	0	0	0	0	0	0	0	0	(1,602)	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	0	250	0	0	0	0	0	0	0	0	0	250	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**	(1,602)	250	0	0	0	0	0	0	0	0	0	(1,352)	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	(323)	7,314	0	0	0	0	0	0	0	0	0	6,991	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,920)	0	0	0	0	0	0	0	0	0	0	(3,920)	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**	(4,243)	7,314	0	0	0	0	0	0	0	0	0	3,071	16
	C. General Administration													
17	Administrative	0	(361,299)	0	0	0	0	0	0	0	0	0	(361,299)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,336	0	0	0	0	0	0	0	0	0	17,336	19
20	Fees, Subscriptions & Promotions	(35,063)	795	0	0	0	0	0	0	0	0	0	(34,268)	20
21	Clerical & General Office Expenses	(4,292)	216,020	279	0	0	0	0	0	0	0	0	212,007	21
22	Employee Benefits & Payroll Taxes	0	28,379	0	0	0	0	0	0	0	0	0	28,379	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,532	0	0	0	0	0	0	0	0	0	6,532	24
25	Other Admin. Staff Transportation	0	4,891	0	0	0	0	0	0	0	0	0	4,891	25
26	Insurance-Prop.Liab.Malpractice	0	2,798	0	0	0	0	0	0	0	0	0	2,798	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(39,355)	(84,548)	279	0	0	0	0	0	0	0	0	(123,624)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(45,200)	(76,984)	279	0	0	0	0	0	0	0	0	(121,905)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 **Report Period Beginning:** 1/01/13 **Ending:** 12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	244	5,690	10,997	0	0	0	0	0	0	0	0	16,931	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,159)	0	0	0	0	0	0	0	0	0	0	(21,159)	32
33	Real Estate Taxes	0	43	0	0	0	0	0	0	0	0	0	43	33
34	Rent-Facility & Grounds	0	12,088	3,007	0	0	0	0	0	0	0	0	15,095	34
35	Rent-Equipment & Vehicles	0	0	(42,173)	0	0	0	0	0	0	0	0	(42,173)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,915)	17,821	(28,169)	0	0	0	0	0	0	0	0	(31,263)	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)	(66,115)	(59,163)	(27,890)	0	0	0	0	0	0	0	0	(153,168)	45

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100%	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Carbondale	Carbondale, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical Supply	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	$	Bridgemark Healthcare, LLC	100.00%	$ 250	$ 250	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	7,314	7,314	2
3	V	17	Management Fees	396,300	Bridgemark Healthcare, LLC	100.00%	35,001	(361,299)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	17,336	17,336	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	795	795	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	216,020	216,020	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	28,379	28,379	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	6,532	6,532	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,891	4,891	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,798	2,798	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	5,690	5,690	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	43	43	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	12,088	12,088	13
14	Total			$ 396,300			$ 337,137	$ * (59,163)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	21	Clerical & Office Supplies	$	Bridgemark Medical Supply	100.00%	$ 279	$ 279	15
16	V	30	Depreciation		Bridgemark Medical Supply	100.00%	10,997	10,997	16
17	V	34	Building Rent		Bridgemark Medical Supply	100.00%	3,007	3,007	17
18	V	35	Equipment Rental	42,173	Bridgemark Medical Supply	100.00%		(42,173)	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			$ 42,173			$ 14,283	$ * (27,890)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	266,588	5.8	11.61	Distribution	$ 35,001	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	$ 35,001		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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	260,600	10	$ 2,150	$	30,244	$ 250	1
2	10	Nursing & Medical Records	Resident Days	260,600	10	63,025	63,025	30,244	7,314	2
3	17	Owners Compensation	Resident Days	260,600	10	301,589		30,244	35,001	3
4	19	Professional Fees	Resident Days	260,600	10	149,373		30,244	17,336	4
5	20	Dues, Subscriptions	Resident Days	260,600	10	6,850		30,244	795	5
6	21	Salaries- Other	Resident Days	260,600	10	1,295,190	1,295,190	30,244	150,314	6
7	21	Clerical & Office Supplies	Resident Days	260,600	10	566,161		30,244	65,706	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	260,600	10	244,527		30,244	28,379	8
9	24	Seminars	Resident Days	260,600	10	56,285		30,244	6,532	9
10	25	Admin Staff Travel	Resident Days	260,600	10	42,147		30,244	4,891	10
11	26	Insurance	Resident Days	260,600	10	24,107		30,244	2,798	11
12	30	Depreciation	Resident Days	260,600	10	49,028		30,244	5,690	12
13	33	Real Estate Taxes	Resident Days	260,600	10	374		30,244	43	13
14	34	Building Rent	Resident Days	260,600	10	95,749		30,244	11,112	14
15	34	Rental-Storage Unit	Resident Days	260,600	10	8,407		30,244	976	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,904,962	$ 1,358,215		$ 337,137	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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 & Office Supplies	Revenue	98,304	7	$ 651	$	42,173	$ 279	1
2	30	Depreciation	Revenue	98,304	7	25,634		42,173	10,997	2
3	34	Building Rent	Revenue	98,304	7	7,010		42,173	3,007	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,295	$		$ 14,283	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X			10/22/09				Variable	21,159	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 21,159	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(21,159)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (21,159)	14
15	TOTALS (line 9+line14)						$	$			$	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 Hlthcare of Belleville # 0048827 **Report Period Beginning:** 1/01/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)		$ 64,302	2
3. Under or (over) accrual (line 2 minus line 1).		$ 64,302	3
4. Real Estate Tax accrual used for 2013 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.		$ 64,302	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008	80,745	8
2009	73,277	9
2010	64,585	10
2011	64,572	11
2012	64,439	12

64,302 Line 7, Real Estate Tax portion of Lease Payment
43 Bridgemark Healthcare Allocation
64,345 Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Hlthcare of Belleville COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048827

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-12.0-213-024	Penns 2nd Bub Lot/Sec-61 PT LTS	$ 64,439.34	$ 64,439.34
2.		61, 62 & 64	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,439.34	$ 64,439.34

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

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

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

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	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plasterers			2007	6,731	336	20	336		2,356	9
10	A/C Units			2007	1,072		5			1,072	10
11	Water Heater			2007	2,945		5			2,945	11
12	Air Units			2007	1,215	122	10	122		850	12
13	Supplies for Sign			2007	1,060	106	10	106		742	13
14	100 Gal. Water Heater			2008	8,183	818	10	818		4,636	14
15	Vanities			2008	810	81	10	81		486	15
16	Windows			2008	1,065	53	20	53		284	16
17	Sprinklers			2008	7,898	527	15	527		2,764	17
18	Asphalt for Rear of Building			2008	2,085	261	8	261		1,325	18
19	New Water Pump			2008	1,439	144	10	144		732	19
20	New Nurse's Station & Renovation of front entrance & hallways			2009	35,615	2,374	15	2,374		10,404	20
21	Asphalt for Front of Building			2009	1,295	162	8	162		715	21
22	Cabinets			2009	3,965	264	15	264		1,145	22
23	Carpet			2009	9,553	1,911	5	1,911		8,279	23
24	14 Doors			2009	4,382	292	15	292		1,217	24
25	Water Heater			2009	4,415	442	10	442		1,840	25
26	Cable Installation			2009	8,031	803	10	803		3,280	26
27	Wing Remodel-carpet,hand rails,paint,nurses station,plumbing,doors			2010	56,248	2,812	20	2,812		9,140	27
28	Rooftop Heater & Compressor			2010	6,782	452	15	452		1,695	28
29	Cabinets for utility			2010	1,023	68	15	68		239	29
30	Tile & Carpet			2010	4,793	959	5	959		3,275	30
31	Coutertops			2010	1,352	90	10	90		308	31
32	Facility Signage			2010	3,292	329	10	329		1,042	32
33	Kick Plates for Hallway			2010	431	86	5	86		273	33
34	A/C Units			2011	6,876	688	10	688		2,006	34
35	Shower Room-Flooring, electric, shower heads, fixtures, paint			2011	9,427	628	15	628		1,309	35
36	A/C Units			2011	6,675	1,335	5	1,335		3,464	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	2 Add'l cameras for security system	2012	$ 594	$ 119	5	$ 119	$	$ 198	37
38	New Amp Meter	2012	595	60	10	60		99	38
39	Replaced security system keypad	2012	717	72	10	72		114	39
40	HVAC System	2012	6,755	450	15	450		676	40
41	Entrance Door	2012	2,397	160	15	160		186	41
42	PTAC Units	2012	2,169	217	10	217		290	42
43	Water Heater Booster	2012	1,448	145	10	145		181	43
44	Frigidaire PTAC Units	2013	2,895	212	5	212		212	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54	Related Party Allocation - Bridgemark Healthcare LLC								54
55	New Office Build-Out	2011	15,762		20	835	835	2,048	55
56	Conference Rm Chair Rail & Paint	2012	178		5	36	36	48	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)		$ 232,168	$ 17,578		$ 18,449	$ 871	$ 71,875	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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	$ 151,254	$ 11,843	$ 24,335	$ 12,492	5-10	$ 61,507	71
72	Current Year Purchases	354,402	10,761	13,169	2,408	5-10	13,169	72
73	Fully Depreciated Assets	29,467					29,467	73
74								74
75	TOTALS	$ 535,123	$ 22,604	$ 37,504	$ 14,900		$ 104,143	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Ford E-450	2010	$ 4,000	$	$ 1,000	$ 1,000	4	$ 3,500	76
77	Related Party Allocation - Bridgemark			1,542		160	160	4	1,542	77
78										78
79										79
80	TOTALS			$ 5,542	$	$ 1,160	$ 1,160		$ 5,042	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)	$ 772,833	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,182	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,113	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,931	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 181,060	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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Belleville Illinois, L.L.C.

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		122		$ 627,573			3
4	Additions							4
5	Related Party Allocation-Bridgemark				15,095			5
6								6
7	TOTAL		122		$ 642,668 **			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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 233,277 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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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				3,793		3,793	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				189,673		189,673	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					184,067		184,067	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				615,515			615,515	13
14	TOTAL			$		$ 615,515	$ 377,533		$ 993,048	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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,602	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 318,900)	1,951,199		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	275		7
8	Accounts Receivable (owners or related parties)	2,895,216		8
9	Other(specify): Deposits	483		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,848,775	$	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	528,504		15
16	Equipment, at Historical Cost	84,022		16
17	Accumulated Depreciation (book methods)	(118,229)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	66,373		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 560,670	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,409,445	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 755,038	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,955		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,187		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,372		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	37,859		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,115,411	$	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	Capital Lease - Ventilators	305,762		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 305,762	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,421,173	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,988,272	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,409,445	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,239,423	1
2	Restatements (describe):		2
3	**Adjustments made after prior year cost report file:**		3
4	**Accounts Receivable Adjustment**	67,915	4
5	**W/C and Unemployment Adjustment**	31,971	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,339,309	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	648,963	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)**	$ 648,963	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)**	$ 3,988,272	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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	$ 7,555,245	1
2	Discounts and Allowances for all Levels	(223,777)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,331,468	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	202,175	6
7	Oxygen	94,757	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 296,932	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	3,920	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)**	$ 3,920	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	90,740	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90,740	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	323	28
28a	Miscellaneous Income	652	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 975	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,724,035	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	865,520	31
32	Health Care	2,687,634	32
33	General Administration	1,272,863	33
	B. Capital Expense		
34	Ownership	1,029,979	34
	C. Ancillary Expense		
35	Special Cost Centers	989,255	35
36	Provider Participation Fee	229,821	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,075,072	40
41	**Income before Income Taxes (line 30 minus line 40)****	648,963	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 648,963	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,459,308	44
45	Private Pay - Net Inpatient Revenue	456,380	45
46	Medicare - Net Inpatient Revenue	1,865,188	46
47	Other-(specify) Insurance	224,655	47
48	Other-(specify) Hospice	325,937	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,331,468	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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,323	1,360	$ 39,948	$ 29.37	1
2	Assistant Director of Nursing	2,028	2,292	76,345	33.31	2
3	Registered Nurses	7,398	8,100	236,192	29.16	3
4	Licensed Practical Nurses	23,519	26,174	584,660	22.34	4
5	CNAs & Orderlies	51,661	55,726	665,588	11.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,899	5,300	89,873	16.96	8
9	Activity Director					9
10	Activity Assistants	3,870	4,323	61,759	14.29	10
11	Social Service Workers	1,336	1,599	38,458	24.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,676	15,695	164,439	10.48	15
16	Dishwashers					16
17	Maintenance Workers	1,983	2,187	62,876	28.75	17
18	Housekeepers	11,536	12,352	114,684	9.28	18
19	Laundry	3,182	3,441	33,434	9.72	19
20	Administrator	1,663	1,927	61,511	31.92	20
21	Assistant Administrator					21
22	Other Administrative	4,447	4,672	74,789	16.01	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,473	1,568	29,110	18.57	31
32	Other Health C: Resp. Therapy	18,354	20,523	500,182	24.37	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,348	167,239	$ 2,833,848 *	$ 16.94	34

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

** See instructions.

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		$ 12,501	1,3	35
36	Medical Director		34,800	9,3	36
37	Medical Records Consultant		2,439	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,392	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		8,896	11,3	44
45	Social Service Consultant		3,083	12,3	45
46	Other(specify) Psych Consultant		4,538	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 70,649		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

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sara Farmer	Administrator	0	$ 61,511
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,511

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 396,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 396,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,430
Ceridian	Payroll Processing	17,069
Personnel Planners, Inc	Unemployment Consulting	2,724
Hamlin & Burton	MSP Reporting	650
Kramer & Frank	Legal	275
Brown & James	Arbitration Judgement	9,788
Michael Parentin	IL Web Annual Report	309
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 35,245

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,995
Unemployment Compensation Insurance	127,030
FICA Taxes	216,554
Employee Health Insurance	30,848
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	6,064
Employee Benefits	5,536
Other Employee Insurance	7,426
Related Party Allocation-Bridgemark	28,379
TOTAL (agree to Schedule V, line 22, col.8)	$ 532,832

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	10,190
Health Care Worker Background Check	
(Indicate # of checks performed)	3,255
Patient Background Checks	
Dues & Subscriptions	1,705
Late Fees	7,418
Miscellaneous Licenses & Fees	654
Related Party Allocation-Bridgemark	795
Advertising	25,755
Less: Public Relations Expense	( )
Non-allowable advertising	(25,755)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,007

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	840
Seminar Expense	1,128
Related Pary Allocation-Bridgemark	6,532
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,500

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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 Hlthcare of Belleville # 0048827 Report Period Beginning: 1/01/13 Ending: 12/31/13

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? **No**
If YES, give association name and amount. **N/A**

(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. $ **883** 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. $ **229,821**
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. $ **None** Has any meal income been offset against related costs? **None** Indicate the amount. $ **N/A**

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

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

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

(19) 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 Belleville
Attachment to Schedule XII B
Equipment Rentals
12/31/2013

	Description		
16A	Specialty Bed Rental	$	191,235
16B	Respiratory Equipment		35,927
16C	Copier Lease		6,115
		$	233,277