		FOR BHF USE				

LL1

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

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.

I. IDPH License ID Number: 0049775

Facility Name: Helia Healthcare of Benton

Address: 1310 Mark Franklin Louis St (Number) Benton (City) 62812 (Zip Code)

County: Franklin

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/13 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) 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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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 ______

	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	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,048	6,559	6,060	25,667	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,048	6,559	6,060	25,667	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.72%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 5,844

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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	100,459	12,571	164,077	277,107		277,107		277,107			1
2	Food Purchase		285,501		285,501		285,501	(361)	285,140			2
3	Housekeeping	89,628	25,736		115,364		115,364		115,364			3
4	Laundry	17,160	13,957	161,259	192,376		192,376		192,376			4
5	Heat and Other Utilities			92,643	92,643		92,643	(3,966)	88,677			5
6	Maintenance	32,126	12,997	30,122	75,245		75,245	18,876	94,121			6
7	Other (specify):*											7
8	**TOTAL General Services**	239,373	350,762	448,101	1,038,236		1,038,236	14,549	1,052,785			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,166,098	69,358	10,057	1,245,513		1,245,513	6,207	1,251,720			10
10a	Therapy		967		967		967		967			10a
11	Activities	34,865	13,267	1,803	49,935		49,935	(261)	49,674			11
12	Social Services	27,198	67	1,548	28,813		28,813		28,813			12
13	CNA Training											13
14	Program Transportation		123		123		123		123			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,228,161	83,782	25,408	1,337,351		1,337,351	5,946	1,343,297			16
	C. General Administration											
17	Administrative	68,991		250,000	318,991		318,991	(220,296)	98,695			17
18	Directors Fees											18
19	Professional Services			21,734	21,734		21,734	15,783	37,517			19
20	Dues, Fees, Subscriptions & Promotions			68,115	68,115		68,115	(54,732)	13,383			20
21	Clerical & General Office Expenses	50,328	16,192	39,743	106,263		106,263	181,217	287,480			21
22	Employee Benefits & Payroll Taxes			312,954	312,954		312,954	32,960	345,914			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,174	2,174		2,174	5,544	7,718			24
25	Other Admin. Staff Transportation			8,208	8,208		8,208	10,625	18,833			25
26	Insurance-Prop.Liab.Malpractice			34,194	34,194		34,194	2,612	36,806			26
27	Other (specify):*											27
28	**TOTAL General Administration**	119,319	16,192	737,122	872,633		872,633	(26,287)	846,346			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,586,853	450,736	1,210,631	3,248,220		3,248,220	(5,792)	3,242,428			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			25,408	25,408		25,408	14,599	40,007			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,958	33,958		33,958	(25,841)	8,117			32
33	Real Estate Taxes			24,000	24,000		24,000	3,037	27,037			33
34	Rent-Facility & Grounds			302,950	302,950		302,950	(285,835)	17,115			34
35	Rent-Equipment & Vehicles			23,965	23,965		23,965	(2,475)	21,490			35
36	Other (specify):*			2,466	2,466		2,466		2,466			36
37	**TOTAL Ownership**			412,747	412,747		412,747	(296,515)	116,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,537	648,289	825,826		825,826		825,826			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,464	174,464		174,464		174,464			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		177,537	822,753	1,000,290		1,000,290		1,000,290			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,586,853	628,273	2,446,131	4,661,257		4,661,257	(302,307)	4,358,950			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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(261)	11		4
5	Telephone, TV & Radio in Resident Rooms	(5,124)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25,841)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(361)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(300)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,066)	21		19
20	Contributions	(375)	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	(49,217)	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	(5,890)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,435)		$	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)	(211,872)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (211,872)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (302,307)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Helia Healthcare of Benton

ID# 0049775

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts and Flowers	$ (7,880)	20	1
2	Record 2013 IDPH license paid in prior year	1,990	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**	(5,890)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(361)	0	0	0	0	0	0	0	0	0	0	(361)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,124)	946	212	0	0	0	0	0	0	0	0	(3,966)	5
6	Maintenance	0	18,876	0	0	0	0	0	0	0	0	0	18,876	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,485)	19,822	212	0	0	0	0	0	0	0	0	14,549	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	6,207	0	0	0	0	0	0	0	0	6,207	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(261)	0	0	0	0	0	0	0	0	0	0	(261)	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	(261)	0	6,207	0	0	0	0	0	0	0	0	5,946	16
	C. General Administration													
17	Administrative	0	0	(220,296)	0	0	0	0	0	0	0	0	(220,296)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,071	14,712	0	0	0	0	0	0	0	0	15,783	19
20	Fees, Subscriptions & Promotions	(55,407)	0	675	0	0	0	0	0	0	0	0	(54,732)	20
21	Clerical & General Office Expenses	(3,441)	1,314	183,344	0	0	0	0	0	0	0	0	181,217	21
22	Employee Benefits & Payroll Taxes	0	8,876	24,084	0	0	0	0	0	0	0	0	32,960	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,544	0	0	0	0	0	0	0	0	5,544	24
25	Other Admin. Staff Transportation	0	6,474	4,151	0	0	0	0	0	0	0	0	10,625	25
26	Insurance-Prop.Liab.Malpractice	0	238	2,374	0	0	0	0	0	0	0	0	2,612	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,848)	17,973	14,588	0	0	0	0	0	0	0	0	(26,287)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(64,594)	37,795	21,007	0	0	0	0	0	0	0	0	(5,792)	29

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	884	13,715	0	0	0	0	0	0	0	0	14,599	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,841)	0	0	0	0	0	0	0	0	0	0	(25,841)	32
33	Real Estate Taxes	0	3,000	37	0	0	0	0	0	0	0	0	3,037	33
34	Rent-Facility & Grounds	0	1,680	(287,515)	0	0	0	0	0	0	0	0	(285,835)	34
35	Rent-Equipment & Vehicles	0	0	(2,475)	0	0	0	0	0	0	0	0	(2,475)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,841)	5,564	(276,238)	0	0	0	0	0	0	0	0	(296,515)	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)**	(90,435)	43,359	(255,231)	0	0	0	0	0	0	0	0	(302,307)	45

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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 Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Carbondale	Carbondale, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Helia Healthcare Services	100.00%	$ 946	$ 946	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	21,876	18,876	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	1,071	1,071	3
4	V	21	Clerical & General Office		Helia Healthcare Services	100.00%	1,314	1,314	4
5	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	8,876	8,876	5
6	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	6,474	6,474	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	238	238	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	884	884	8
9	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,000	3,000	9
10	V	34	Rent-Facility & Grounds		Helia Healthcare Services	100.00%	1,680	1,680	10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,000			$ 46,359	$ * 43,359	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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		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	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 212	$ 212	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	6,207	6,207	16
17	V	17	Administrative	250,000	Bridgemark Healthcare, LLC	100.00%	29,704	(220,296)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	14,712	14,712	18
19	V	20	Dues,Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	675	675	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	183,328	183,328	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,084	24,084	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,544	5,544	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,151	4,151	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,374	2,374	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,829	4,829	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	37	37	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	9,431	9,431	27
28	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	828	828	28
29	V								29
30	V								30
31	V	30	Depreciation		BM Properties I - Benton	100.00%	8,241	8,241	31
32	V	34	Rent - Facility & Grounds	302,950	BM Properties I - Benton	100.00%	5,000	(297,950)	32
33	V								33
34	V	21	Clerical & General Office Expenses		Bridgemark Medical Supply	100.00%	16	16	34
35	V	30	Depreciation		Bridgemark Medical Supply	100.00%	645	645	35
36	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	176	176	36
37	V	35	Equipment Rental	2,475	Bridgemark Medical Supply	100.00%		(2,475)	37
38	V								38
39	Total			$ 555,425			$ 300,194	$ * (255,231)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	271,885	4.92	9.85	Distribution	$ 29,704	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	$ 29,704		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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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 [ ]

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 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	$	25,667	$ 212	1
2	10	Nursing & Medical Records	Resident Days	260,600	10	63,025	63,025	25,667	6,207	2
3	17	Owners Compensation	Resident Days	260,600	10	301,589		25,667	29,704	3
4	19	Professional Fees	Resident Days	260,600	10	149,373		25,667	14,712	4
5	20	Dues, Subscriptions	Resident Days	260,600	10	6,850		25,667	675	5
6	21	Salaries-Other	Resident Days	260,600	10	1,295,190	1,295,190	25,667	127,566	6
7	21	Clerical & Office Supplies	Resident Days	260,600	10	566,161		25,667	55,762	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	260,600	10	244,527		25,667	24,084	8
9	24	Seminars	Resident Days	260,600	10	56,285		25,667	5,544	9
10	25	Admin Staff Travel	Resident Days	260,600	10	42,147		25,667	4,151	10
11	26	Insurance	Resident Days	260,600	10	24,107		25,667	2,374	11
12	30	Depreciation	Resident Days	260,600	10	49,028		25,667	4,829	12
13	33	Real Estate Taxes	Resident Days	260,600	10	374		25,667	37	13
14	34	Building Rent	Resident Days	260,600	10	95,749		25,667	9,431	14
15	34	Building Rent	Resident Days	260,600	10	8,407		25,667	828	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		$ 286,116	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Revenue	12,000	4	$ 3,782	$	3,000	$ 946	1
2	6	Mainenance	Revenue	12,000	4	87,502		3,000	21,876	2
3	19	Professional Services	Revenue	12,000	4	4,285		3,000	1,071	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	5,255		3,000	1,314	4
5	22	Payroll Taxes & Emp. Ben.	Revenue	12,000	4	35,504		3,000	8,876	5
6	25	Other Admin Transportation	Revenue	12,000	4	25,895		3,000	6,474	6
7	26	Insurance	Revenue	12,000	4	950		3,000	238	7
8	30	Depreciation	Revenue	12,000	4	3,535		3,000	884	8
9										9
10	33	Real Estate Taxes	Revenue	12,000	4	12,000		3,000	3,000	10
11	34	Rent	Revenue	12,000	4	6,720		3,000	1,680	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					$ 185,428	$		$ 46,359	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & General Office	Revenue	98,304	7	$ 651	$	2,475	$ 16	1
2	30	Depreciation	Revenue	98,304	7	25,634		2,475	645	2
3	34	Rent - Facility & Grounds	Revenue	98,304	7	7,010		2,475	176	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	$		$ 837	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit	10/22/09					Variable	33,958	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 33,958	9
	B. Non-Facility Related*											
10	Interest Income		X								(25,841)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,841)	14
15	TOTALS (line 9+line14)						$	$			$ 8,117	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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2012 report.	$	81,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(81,000)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	105,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	24,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011	See note on	11
2012	Tax Statement	12

$24,000 Line 7: Estimate of property taxes when the county separates the parcel to Bridgemark

	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 Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

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

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

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES X ________ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: ______ 2. Number of Years Over Which it is Being Amortized: ______

3. Current Period Amortization: ______ 4. Dates Incurred: ______

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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	Helia Healthcare Allocation		2006		$ 7,450	$	25	$ 373	$ 373	$ 2,918	4
5	83		2008		134,098		30	4,470	4,470	24,212	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		400	9
10	Exterior Sign			2009	5,265	527	10	527		2,541	10
11	Landscaping			2009	4,135	414	10	414		1,964	11
12	Wallcovering for hallways & Entranceway, doors, shower remodel			2009	11,252	750	15	750		3,251	12
13	Carpet			2009	1,170	234	5	234		1,014	13
14	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		724	14
15	New Pipes, Install Eye Wash			2010	2,215	89	25	89		318	15
16	AC, fans, dehumidifier			2010	1,609	161	10	161		563	16
17	Outside single door & frame			2010	4,168	278	15	278		903	17
18	Shower Room - Tile, shower heads, electrical work, fixtures, paint			2011	3,860	257	15	257		664	18
19	Dinette/Common area remodel - doors, windows, counters, cabinetry										19
20	(cont.) flooring, electrical, plywood, paint			2011	13,693	913	15	913		2,359	20
21	Back-Up Generator			2011	12,864	643	20	643		1,501	21
22	Sprinkler System			2012	97,800	3,912	25	3,912		7,824	22
23	Fire Doors			2012	9,943	663	15	663		1,215	23
24	Oxygen Shed			2012	1,941	194	10	194		275	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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	Related Party Allocation - Helia Healthcare		$	$		$	$	$	37
38	Water & Sewer Pipe Installation	2006	475		20	24	24	176	38
39	Plumbing & Heating Installation	2006	569		20	29	29	211	39
40	A/C Unit - 4 Ton	2007	1,370		10	137	137	913	40
41									41
42	Related Party Allocation - Bridgemark Healthcare LLC								42
43	New Office Build-Out	2011	13,377		20	708	708	1,738	43
44	Conference Rm Chair Rail & Paint	2012	151		5	30	30	40	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 331,182	$ 9,286		$ 15,057	$ 5,771	$ 55,724	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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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	$ 118,567	$ 7,970	$ 15,815	$ 7,845	7	$ 49,074	71
72	Current Year Purchases	11,883	947	1,514	567	7	1,514	72
73	Fully Depreciated Assets	41,383					41,383	73
74								74
75	TOTALS	$ 171,833	$ 8,917	$ 17,329	$ 8,412		$ 91,971	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party Allocation-Bridgemark		2005	$ 1,309	$	$ 135	$ 135	5	$ 1,309	76
77	Related Party Allocation-Helia		2006	1,678		281	281	5	1,655	77
78	Facility	Bus	2011	28,821	7,205	7,205		4	19,815	78
79										79
80	TOTALS			$ 31,808	$ 7,205	$ 7,621	$ 416		$ 22,779	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)	$ 536,073	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,408	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,007	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,599	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 170,474	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

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

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .
9. Option to Buy: [ ] YES [X] NO Terms: ______ *

10. Effective dates of current rental agreement:
    Beginning ______
    Ending ______

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 21,490 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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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

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		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				143,062		143,062	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					34,475		34,475	12
13	Other (specify): Lab, Xray, Therapy	39,3				648,289			648,289	13
14	TOTAL			$		$ 648,289	$ 177,537		$ 825,826	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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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	$ 8,711	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 61,000)	625,826		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,031,178		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,665,714	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	173,691		15
16	Equipment, at Historical Cost	130,735		16
17	Accumulated Depreciation (book methods)	(97,100)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 207,326	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,873,040	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 630,742	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,029		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,264		31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	40,287		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 883,321	$	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	Note Payable - Owner	123,729		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 123,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,007,050	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,865,990	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,873,040	$	48

SEE ACCOUNTANTS' COMPILATION REPORT *(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,478,339	1
2	Restatements (describe):		2
3	**Prior year adjustments made after the cost report was filed:**		3
4	**Accounts Receivable adjustments**	(24,728)	4
5	**W/C and unemployment adjustment**	7,933	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,461,544	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	404,446	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)**	$ 404,446	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)**	$ 2,865,990	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 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	$ 4,828,725	1
2	Discounts and Allowances for all Levels	33,826	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,862,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	175,395	6
7	Oxygen	1,655	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 177,050	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,841	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,841	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending	261	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 261	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,065,703	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,042,352	31
32	Health Care	1,354,293	32
33	General Administration	850,608	33
	B. Capital Expense		
34	Ownership	412,747	34
	C. Ancillary Expense		
35	Special Cost Centers	826,793	35
36	Provider Participation Fee	174,464	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,661,257	40
41	**Income before Income Taxes (line 30 minus line 40)****	404,446	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 404,446	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,337,821	44
45	Private Pay - Net Inpatient Revenue	855,075	45
46	Medicare - Net Inpatient Revenue	2,617,329	46
47	Other-(specify)	46,517	47
48	Other-(specify)	5,809	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,862,551	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed 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 Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,510	1,734	$ 55,481	$ 32.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,304	8,543	179,764	21.04	3
4	Licensed Practical Nurses	15,469	16,826	283,841	16.87	4
5	CNAs & Orderlies	58,900	63,675	644,742	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,039	3,299	34,865	10.57	10
11	Social Service Workers	1,545	1,698	27,198	16.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,535	9,377	100,459	10.71	15
16	Dishwashers					16
17	Maintenance Workers	1,894	2,111	32,126	15.22	17
18	Housekeepers	9,868	10,381	89,628	8.63	18
19	Laundry	1,646	1,819	17,160	9.43	19
20	Administrator	1,920	2,082	68,991	33.14	20
21	Assistant Administrator					21
22	Other Administrative	1,333	1,461	16,462	11.27	22
23	Office Manager	1,729	1,977	33,866	17.13	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	116	133	2,270	17.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,808	125,116	$ 1,586,853 *	$ 12.68	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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		$		35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		1,331	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,565	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		100	10,3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,803	11,3	44
45	Social Service Consultant		1,548	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,347		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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Hensgen	Administrator	0	$ 6,268
Steven Johnson	Administrator	0	62,723
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,991

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 5,053
Ceridian	Payroll Processing	13,692
Capital One	Tracking Forms	209
Personnel Planners, Inc.	Unemployment Consultant	2,248
Center for Medicare	CMS Revalidation	532
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,734

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,412
Unemployment Compensation Insurance	91,825
FICA Taxes	121,979
Employee Health Insurance	24,381
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,550
Employee Benefits	2,695
Uniforms	827
Employee Insurance	3,285
Related Party Allocation-Bridgemark	24,084
Related Party Allocation-Helia	8,876
TOTAL (agree to Schedule V, line 22, col.8)	$ 345,914

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	5,552
Health Care Worker Background Check (Indicate # of checks performed)	2,504
Patient Background Checks	
Dues & Subscriptions	501
Late Fees	2,161
Related Party Allocation-Bridgemark	675
Advertising	49,217
Less: Public Relations Expense	( )
Non-allowable advertising	(49,217)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,383

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	269
Seminar Expense	1,905
Related Pary Allocation-Bridgemark	5,544
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,718

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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
					Amount of Expense Amortized Per Year								
	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

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? **5-10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,045** 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. $ **174,464**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2013

	Description	
16A	Nursing Equipment Rental	$ 18,918
16C	Copier Lease	2,572
		$ 21,490