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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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) 397-8400 **Fax #** (618) 397-8470

HFS ID Number:

Date of Initial License for Current Owners: 12/01/07

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 01/01/14 to 12/31/14 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: 01/01/14 Ending: 12/31/14

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	19,114	1,003	12,017	32,134	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,114	1,003	12,017	32,134	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.16%

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 3,849

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

* 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: 01/01/14 Ending: 12/31/14

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	182,902	27,807	7,227	217,936		217,936		217,936			1
2	Food Purchase		189,271		189,271		189,271	(6,439)	182,832			2
3	Housekeeping	157,851	40,154	3,557	201,562		201,562		201,562			3
4	Laundry	11,814	43,423		55,237		55,237		55,237			4
5	Heat and Other Utilities			124,212	124,212		124,212	293	124,505			5
6	Maintenance	63,659	23,753	136,438	223,850		223,850		223,850			6
7	Other (specify):*											7
8	TOTAL General Services	416,226	324,408	271,434	1,012,068		1,012,068	(6,146)	1,005,922			8
	B. Health Care and Programs											
9	Medical Director			34,800	34,800		34,800		34,800			9
10	Nursing and Medical Records	2,056,340	333,068	40,262	2,429,670		2,429,670	17,903	2,447,573			10
10a	Therapy	600,808	1,748		602,556		602,556		602,556			10a
11	Activities	65,859	12,957	8,192	87,008		87,008	(1,500)	85,508			11
12	Social Services	39,812		2,844	42,656		42,656		42,656			12
13	CNA Training											13
14	Program Transportation			32,930	32,930		32,930		32,930			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,762,819	347,773	119,028	3,229,620		3,229,620	16,403	3,246,023			16
	C. General Administration											
17	Administrative	77,481		456,500	533,981		533,981	(379,672)	154,309			17
18	Directors Fees											18
19	Professional Services			30,326	30,326		30,326	3,245	33,571			19
20	Dues, Fees, Subscriptions & Promotions			94,935	94,935		94,935	(47,016)	47,919			20
21	Clerical & General Office Expenses	76,354	37,650	80,473	194,477		194,477	209,857	404,334			21
22	Employee Benefits & Payroll Taxes			552,260	552,260		552,260	32,910	585,170			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,507	6,507		6,507	7,164	13,671			24
25	Other Admin. Staff Transportation			10,012	10,012		10,012	7,764	17,776			25
26	Insurance-Prop.Liab.Malpractice			47,868	47,868		47,868	3,411	51,279			26
27	Other (specify):*											27
28	TOTAL General Administration	153,835	37,650	1,278,881	1,470,366		1,470,366	(162,337)	1,308,029			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,332,880	709,831	1,669,343	5,712,054		5,712,054	(152,080)	5,559,974			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: 01/01/14 Ending: 12/31/14

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			62,421	62,421		62,421	13,728	76,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,037	30,037		30,037	(1,526)	28,511			32
33	Real Estate Taxes			64,214	64,214		64,214	34	64,248			33
34	Rent-Facility & Grounds			646,400	646,400		646,400	15,598	661,998			34
35	Rent-Equipment & Vehicles			294,311	294,311		294,311	(43,578)	250,733			35
36	Other (specify):* Loss on Disposal			2,576	2,576		2,576		2,576			36
37	TOTAL Ownership			1,099,959	1,099,959		1,099,959	(15,744)	1,084,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		548,213	670,207	1,218,420		1,218,420		1,218,420			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,031	235,031		235,031		235,031			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		548,213	905,238	1,453,451		1,453,451		1,453,451			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,332,880	1,258,044	3,674,540	8,265,464		8,265,464	(167,824)	8,097,640			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: 01/01/14 Ending: 12/31/14

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	(1,500)	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	(113)	30		9
10	Interest and Other Investment Income	(1,526)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,439)	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	(2,200)	21		18
19	Entertainment	(5,125)	21		19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(32,125)	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	(14,867)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,895)		$	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)	(99,929)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (99,929)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (167,824)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Hlthcare of Belleville

ID# 0048827

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (13,359)	20	1
2	Eliminate Lobbying & PAC Dues	(1,508)	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**	(14,867)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(6,439)	0	0	0	0	0	0	0	0	0	0	(6,439)	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	293	0	0	0	0	0	0	0	0	0	293	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**	(6,439)	293	0	0	0	0	0	0	0	0	0	(6,146)	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	17,903	0	0	0	0	0	0	0	0	0	17,903	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,500)	0	0	0	0	0	0	0	0	0	0	(1,500)	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**	(1,500)	17,903	0	0	0	0	0	0	0	0	0	16,403	16
	C. General Administration													
17	Administrative	0	(379,672)	0	0	0	0	0	0	0	0	0	(379,672)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,200)	6,445	0	0	0	0	0	0	0	0	0	3,245	19
20	Fees, Subscriptions & Promotions	(47,542)	526	0	0	0	0	0	0	0	0	0	(47,016)	20
21	Clerical & General Office Expenses	(7,575)	217,375	57	0	0	0	0	0	0	0	0	209,857	21
22	Employee Benefits & Payroll Taxes	0	32,910	0	0	0	0	0	0	0	0	0	32,910	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,164	0	0	0	0	0	0	0	0	0	7,164	24
25	Other Admin. Staff Transportation	0	7,764	0	0	0	0	0	0	0	0	0	7,764	25
26	Insurance-Prop.Liab.Malpractice	0	3,411	0	0	0	0	0	0	0	0	0	3,411	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(58,317)	(104,077)	57	0	0	0	0	0	0	0	0	(162,337)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(66,256)	(85,881)	57	0	0	0	0	0	0	0	0	(152,080)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(113)	4,856	8,985	0	0	0	0	0	0	0	0	13,728	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	32
33	Real Estate Taxes	0	34	0	0	0	0	0	0	0	0	0	34	33
34	Rent-Facility & Grounds	0	13,483	2,115	0	0	0	0	0	0	0	0	15,598	34
35	Rent-Equipment & Vehicles	0	0	(43,578)	0	0	0	0	0	0	0	0	(43,578)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,639)	18,373	(32,478)	0	0	0	0	0	0	0	0	(15,744)	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)	(67,895)	(67,508)	(32,421)	0	0	0	0	0	0	0	0	(167,824)	45

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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	$	Bridgemark Healthcare, LLC	100.00%	$ 293	$ 293	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	17,903	17,903	2
3	V	17	Management Fees	456,500	Bridgemark Healthcare, LLC	100.00%	76,828	(379,672)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	6,445	6,445	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	526	526	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	217,375	217,375	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	32,910	32,910	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,164	7,164	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	7,764	7,764	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	3,411	3,411	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,856	4,856	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	34	34	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	13,483	13,483	13
14	Total			$ 456,500			$ 388,992	$ * (67,508)	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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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%	$ 57	$ 57	15
16	V	30	Depreciation		Bridgemark Medical Supply	100.00%	8,985	8,985	16
17	V	34	Building Rent		Bridgemark Medical Supply	100.00%	2,115	2,115	17
18	V	35	Equipment Rental	43,865	Bridgemark Medical Supply	100.00%		(43,865)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	35	Equipment Rental		Bridgemark Healthcare LLC	100.00%	287	287	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			$ 43,865			$ 11,444	$ * (32,421)	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: 01/01/14 Ending: 12/31/14

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	516,869	6.47	12.94	Distribution	$ 76,828	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	$ 76,828		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: 01/01/14 Ending: 12/31/14

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	248,320	10	$ 2,267	$	32,134	$ 293	1
2	10	Nursing & Medical Records	Resident Days	248,320	10	138,347	138,347	32,134	17,903	2
3	17	Owners Compensation	Resident Days	248,320	10	593,697		32,134	76,828	3
4	19	Professional Fees	Resident Days	248,320	10	49,802		32,134	6,445	4
5	20	Dues, Subscriptions	Resident Days	248,320	10	4,062		32,134	526	5
6	21	Salaries - Other	Resident Days	248,320	10	1,347,083	1,347,083	32,134	174,320	6
7	21	Clerical & Office Supplies	Resident Days	248,320	10	332,712		32,134	43,055	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	248,320	10	254,317		32,134	32,910	8
9	24	Seminars	Resident Days	248,320	10	55,362		32,134	7,164	9
10	25	Admin Staff Travel	Resident Days	248,320	10	60,000		32,134	7,764	10
11	26	Insurance	Resident Days	248,320	10	26,357		32,134	3,411	11
12	30	Depreciation	Resident Days	248,320	10	37,526		32,134	4,856	12
13	33	Real Estate Taxes	Resident Days	248,320	10	261		32,134	34	13
14	34	Building Rent	Resident Days	248,320	10	94,122		32,134	12,180	14
15	34	Rental - Storage Unit	Resident Days	248,320	10	10,067		32,134	1,303	15
16	35	Equipment Rental	Resident Days	248,320	10	2,216		32,134	287	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,008,198	$ 1,485,430		$ 389,279	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	129,336	8	$ 168	$	43,865	$ 57	1
2	30	Depreciation	Revenue	129,336	8	26,491		43,865	8,985	2
3	34	Building Rent	Revenue	129,336	8	6,237		43,865	2,115	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					$ 32,896	$		$ 11,157	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	30,037	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 30,037	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(1,526)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,526)	14
15	TOTALS (line 9+line14)						$	$			$ 28,511	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: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 66,373	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.)		$ 64,329	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,044)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,258	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.		$ 64,214	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	73,277	8
	2010	64,585	9
	2011	64,572	10
	2012	64,439	11
	2013	64,329	12

64,214 Line 7, Real Estate Tax portion of Lease Payment
34 Bridgemark Healthcare Allocation
64,248 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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

2013 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 2013 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 2013.

	(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	$ 64,328.60	$ 64,328.60
2.		61, 62 &64	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,328.60	$ 64,328.60

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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											9
10	Plasterers			2007	6,731	336	20	336		2,692	10
11	Air Units			2007	1,215	122	10	122		972	11
12	Supplies for Sign			2007	1,060	106	10	106		848	12
13	100 Gal. Water Heater			2008	8,183	818	10	818		5,454	13
14	Vanities			2008	810	81	10	81		567	14
15	Windows			2008	1,065	53	20	53		337	15
16	Sprinklers			2008	7,898	527	15	527		3,291	16
17	Asphalt for Rear of Building			2008	2,085	261	8	261		1,586	17
18	New Water Pump			2008	1,439	144	10	144		876	18
19	New Nurse's Station & Renovation of front entrance & hallways			2009	35,615	2,374	15	2,374		12,778	19
20	Asphalt for Front of Building			2009	1,295	162	8	162		877	20
21	Cabinets			2009	3,965	264	15	264		1,409	21
22	Carpet			2009	9,553	1,274	5	1,274		9,553	22
23	14 Doors			2009	4,382	292	15	292		1,509	23
24	Water Heater			2009	4,415	442	10	442		2,282	24
25	Cable Installation			2009	8,031	803	10	803		4,083	25
26	Wing Remodel-carpet, hand rails, paint, nurses station, plumbing, doors			2010	56,248	2,812	20	2,812		11,952	26
27	Rooftop Heater & Compressor			2010	6,782	452	15	452		2,147	27
28	Cabinets for utility			2010	1,023	68	15	68		307	28
29	Tile & Carpet			2010	4,793	959	5	959		4,234	29
30	Countertops			2010	1,352	90	10	90		398	30
31	Facility Signage			2010	3,292	329	10	329		1,372	31
32	Kick Plates for Hallway			2010	431	86	5	86		359	32
33	A/C Units			2011	6,876	688	10	688		2,694	33
34	Shower Room-Flooring, electric, shower heads, fixtures, paint			2011	9,427	628	15	628		1,937	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 Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	A/C Units	2011	$ 6,675	$ 1,335	5	$ 1,335	$	$ 4,799	37
38	2 Add'l cameras for security system	2012	594	119	5	119		317	38
39	New Amp Meter	2012	595	60	10	60		159	39
40	Replaced security system keypad	2012	717	72	10	72		186	40
41	HVAC System	2012	6,755	450	15	450		1,126	41
42	Entrance Door	2012	2,397	160	15	160		346	42
43	PTAC Units	2012	2,169	217	10	217		507	43
44	Water Heater Booster	2012	1,448	145	10	145		326	44
45	Frigidaire PTAC Units	2013	2,895	579	5	579		791	45
46	Radiator for Generator	2014	3,846	353	10	353		353	46
47	Data Cabling & Wiring	2014	2,812	234	10	234		234	47
48	Hand Rail Lumber	2014	3,486	155	15	155		155	48
49	Nurses Station POC	2014	698	81	5	81		81	49
50	Room Signs	2014	1,695	169	5	169		169	50
51	Frigidaire cool/heater	2014	739	74	5	74		74	51
52	Alarm System	2014	2,350	78	10	78		78	52
53	3 Commodes	2014	828	21	10	21		21	53
54	3 New AC Units	2014	1,901	222	5	222		222	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62	Related Party Allocation - Bridgemark Healthcare LLC								62
63	New Office Build-Out	2011	17,575		20	931	931	3,214	63
64	Conference Room Chair Rail & Paint	2012	199		5	40	40	93	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 248,340	$ 18,695		$ 19,666	$ 971	$ 87,765	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: 01/01/14 Ending: 12/31/14

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	$ 471,769	$ 41,703	$ 53,787	$ 12,084	5-10	$ 110,900	71
72	Current Year Purchases	22,284	1,523	2,196	673	5-10	2,196	72
73	Fully Depreciated Assets	24,039					24,039	73
74								74
75	TOTALS	$ 518,092	$ 43,226	$ 55,983	$ 12,757		$ 137,135	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	$ 500	$ 500	$	4	$ 4,000	76
77	Related Party Allocation - Bridgemark			1,720				4	1,720	77
78										78
79										79
80	TOTALS			$ 5,720	$ 500	$ 500	$		$ 5,720	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)	$ 772,152	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,421	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 76,149	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,728	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 230,620	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 Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 646,400			3
4	Additions							4
5	Related Party Allocation - Bridgemark				15,598			5
6								6
7	TOTAL		122		$ 661,998 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 250,733 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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				1,748		1,748	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				335,738		335,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					212,475		212,475	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				670,207			670,207	13
14	TOTAL			$		$ 670,207	$ 549,961		$ 1,220,168	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: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 1,580	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,200)	1,326,458		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,505		7
8	Accounts Receivable (owners or related parties)	3,948,289		8
9	Other(specify): Deposits	483		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,278,315	$	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	546,858		15
16	Equipment, at Historical Cost	80,844		16
17	Accumulated Depreciation (book methods)	(164,763)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	66,258		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 529,197	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,807,512	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 941,726	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,682		30
31	Accrued Taxes Payable (excluding real estate taxes)	615		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,258		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	29,022		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,185,303	$	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	251,766		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 251,766	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,437,069	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,370,443	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,807,512	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,988,272	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,988,272	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	382,171	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)**	$ 382,171	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,370,443	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: 01/01/14 Ending: 12/31/14

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	$ 8,904,347	1
2	Discounts and Allowances for all Levels	(465,442)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,438,905	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,469	6
7	Oxygen	61,798	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 204,267	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	1,500	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	378	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)**	$ 1,878	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,526	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,526	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	1,059	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,059	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,647,635	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,012,068	31
32	Health Care	3,229,620	32
33	General Administration	1,470,366	33
	B. Capital Expense		
34	Ownership	1,099,959	34
	C. Ancillary Expense		
35	Special Cost Centers	1,218,420	35
36	Provider Participation Fee	235,031	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,265,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	382,171	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 382,171	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,858,637	44
45	Private Pay - Net Inpatient Revenue	281,160	45
46	Medicare - Net Inpatient Revenue	2,209,108	46
47	Other-(specify) Insurance	1,525,055	47
48	Other-(specify) Hospice	564,945	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,438,905	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: 01/01/14 Ending: 12/31/14

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	1,765	1,922	$ 64,005	$ 33.30	1
2	Assistant Director of Nursing	1,960	2,002	58,103	29.02	2
3	Registered Nurses	8,621	9,406	290,825	30.92	3
4	Licensed Practical Nurses	31,273	33,879	750,650	22.16	4
5	CNAs & Orderlies	63,679	68,469	852,251	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,672	1,973	32,895	16.67	8
9	Activity Director					9
10	Activity Assistants	3,811	4,206	65,859	15.66	10
11	Social Service Workers	2,034	2,227	39,812	17.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,037	17,181	182,902	10.65	15
16	Dishwashers					16
17	Maintenance Workers	2,021	2,172	63,659	29.31	17
18	Housekeepers	15,393	16,258	157,851	9.71	18
19	Laundry	974	1,173	11,814	10.07	19
20	Administrator	1,998	2,211	77,481	35.04	20
21	Assistant Administrator					21
22	Other Administrative	3,095	3,560	45,754	12.85	22
23	Office Manager					23
24	Clerical	2,288	2,498	30,600	12.25	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	2,023	2,199	40,506	18.42	31
32	Other Health C: Respiratory Thera	21,143	22,589	567,913	25.14	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,787	193,925	$ 3,332,880 *	$ 17.19	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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		$ 7,227	1,3	35
36	Medical Director		34,800	9,3	36
37	Medical Records Consultant		2,426	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,707	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		8,192	11,3	44
45	Social Service Consultant		2,844	12,3	45
46	Other(specify) Psych Consultant		4,269	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 66,465		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

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sara Farmer	Administrator	0	$ 11,699
Carla Riva	Administrator	0	65,782
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,481

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 456,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 456,500

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 6,062
Ceridian	Payroll Processing	17,039
Personnel Planners, Inc	Unemployment Consulting	3,673
TransAmerica Retirement Solutions	401k Admin Services	352
Kamer & Frank	Collections	3,200
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 30,326

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,629
Unemployment Compensation Insurance	125,195
FICA Taxes	248,916
Employee Health Insurance	24,331
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	5,832
Employee Benefits	4,363
Other Employee Insurance	6,994
Related Party Allocation - Bridgemark	32,910
TOTAL (agree to Schedule V, line 22, col.8)	$ 585,170

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	35,873
Health Care Worker Background Check	3,312
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	2,913
Late Fees	2,529
Miscellaneous Licenses & Fees	776
Related Party Allocation - Bridgemark	526
Advertising	32,125
Less: Public Relations Expense	( )
Non-allowable advertising	(32,125)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,919

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,012
Seminar Expense	5,495
Related Party Allocation - Bridgemark	7,164
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,671

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $2,420**

(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. $ **15,524** 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. $ **235,031**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **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
12/31/2014

	Description	
16A	Specialty Bed Rental	227,709
16B	Respiratory Equipment	12,758
16C	Copier Lease	9,979
16D	Related Party Allocation - Bridgemark Healthcare	287
		250,733

Helia Healthcare of Belleville
Attachment to Schedule XVII
Other Income
12/31/2014

	Description	
28A	Collection Recoveries	130
28B	A/R Deposit	43
28C	Miscellaneous Income	886
		1,059