

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0049775</u></p> <p>Facility Name: <u>Helia Healthcare of Benton</u></p> <p>Address: <u>1310 Mark F Louis St</u> <u>Benton</u> <u>62812</u> <small>Number City Zip Code</small></p> <p>County: <u>Franklin</u></p> <p>Telephone Number: <u>(618) 932-3236</u> Fax # <u>(618) 937-1171</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/15/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775 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	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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,566	4,442	6,451	23,459	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,566	4,442	6,451	23,459	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.44%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/15/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/15/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 83 and days of care provided 5,804

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 Healthcare of Benton

0049775

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				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,701	15,112	162,576	290,389	290,389		290,389			1
2	Food Purchase		281,347		281,347	281,347	(264)	281,083			2
3	Housekeeping	84,847	27,991	165	113,003	113,003		113,003			3
4	Laundry	18,507	50,695	88,969	158,171	158,171		158,171			4
5	Heat and Other Utilities			97,935	97,935	97,935	(3,564)	94,371			5
6	Maintenance	41,419	15,363	37,303	94,085	94,085	15,232	109,317			6
7	Other (specify):*										7
8	TOTAL General Services	257,474	390,508	386,948	1,034,930	1,034,930	11,404	1,046,334			8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000	12,000		12,000			9
10	Nursing and Medical Records	1,152,978	87,588	20,199	1,260,765	1,260,765	13,070	1,273,835			10
10a	Therapy		383		383	383		383			10a
11	Activities	31,705	6,442	1,727	39,874	39,874	(956)	38,918			11
12	Social Services	28,090	82	1,727	29,899	29,899		29,899			12
13	CNA Training										13
14	Program Transportation			677	677	677		677			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,212,773	94,495	36,330	1,343,598	1,343,598	12,114	1,355,712			16
	C. General Administration										
17	Administrative	63,660		254,200	317,860	317,860	(198,113)	119,747			17
18	Directors Fees										18
19	Professional Services			28,595	28,595	28,595	6,104	34,699			19
20	Dues, Fees, Subscriptions & Promotions			73,957	73,957	73,957	(50,796)	23,161			20
21	Clerical & General Office Expenses	71,865	24,471	133,497	229,833	229,833	96,199	326,032			21
22	Employee Benefits & Payroll Taxes			300,859	300,859	300,859	30,813	331,672			22
23	Inservice Training & Education										23
24	Travel and Seminar			4,621	4,621	4,621	5,230	9,851			24
25	Other Admin. Staff Transportation			6,159	6,159	6,159	11,090	17,249			25
26	Insurance-Prop.Liab.Malpractice			38,952	38,952	38,952	3,405	42,357			26
27	Other (specify):*										27
28	TOTAL General Administration	135,525	24,471	840,840	1,000,836	1,000,836	(96,068)	904,768			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,605,772	509,474	1,264,118	3,379,364	3,379,364	(72,550)	3,306,814			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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,786	25,786		25,786	13,129	38,915			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,837	24,837		24,837	(3,300)	21,537			32
33	Real Estate Taxes							25	25			33
34	Rent-Facility & Grounds			302,950	302,950		302,950	(286,253)	16,697			34
35	Rent-Equipment & Vehicles			54,808	54,808		54,808	(3,085)	51,723			35
36	Other (specify):*			1,757	1,757		1,757		1,757			36
37	TOTAL Ownership			410,138	410,138		410,138	(279,484)	130,654			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		227,902	661,658	889,560		889,560		889,560			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			155,924	155,924		155,924		155,924			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		227,902	817,582	1,045,484		1,045,484		1,045,484			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,605,772	737,376	2,491,838	4,834,986		4,834,986	(352,034)	4,482,952			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: 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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(956)	11		4
5	Telephone, TV & Radio in Resident Rooms	(4,775)	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	(3,300)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	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	(150)	20		17
18	Fines and Penalties	(56,612)	21		18
19	Entertainment	(5,422)	21		19
20	Contributions	(1,050)	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	(34,382)	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	(16,648)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (123,559)		\$	30

BHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(228,475)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (228,475)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (352,034)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Benton

ID# 0049775

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts and Flowers	\$ (15,622)	20	1
2	Eliminate Lobbying & PAC Dues	(1,026)	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		(16,648)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton# 0049775

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(264)	0	0	0	0	0	0	0	0	0	0	(264)	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	(4,775)	997	214	0	0	0	0	0	0	0	0	(3,564)	5
6	Maintenance	0	15,232	0	0	0	0	0	0	0	0	0	15,232	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,039)	16,229	214	0	0	0	0	0	0	0	0	11,404	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	13,070	0	0	0	0	0	0	0	0	13,070	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(956)	0	0	0	0	0	0	0	0	0	0	(956)	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	(956)	0	13,070	0	0	0	0	0	0	0	0	12,114	16
	C. General Administration													
17	Administrative	0	0	(198,113)	0	0	0	0	0	0	0	0	(198,113)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,399	4,705	0	0	0	0	0	0	0	0	6,104	19
20	Fees, Subscriptions & Promotions	(51,180)	0	384	0	0	0	0	0	0	0	0	(50,796)	20
21	Clerical & General Office Expenses	(63,084)	587	158,696	0	0	0	0	0	0	0	0	96,199	21
22	Employee Benefits & Payroll Taxes	0	6,787	24,026	0	0	0	0	0	0	0	0	30,813	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,230	0	0	0	0	0	0	0	0	5,230	24
25	Other Admin. Staff Transportation	0	5,422	5,668	0	0	0	0	0	0	0	0	11,090	25
26	Insurance-Prop.Liab.Malpractice	0	915	2,490	0	0	0	0	0	0	0	0	3,405	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(114,264)	15,110	3,086	0	0	0	0	0	0	0	0	(96,068)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(120,259)	31,339	16,370	0	0	0	0	0	0	0	0	(72,550)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Benton

0049775

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	668	12,461	0	0	0	0	0	0	0	0	13,129	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,300)	0	0	0	0	0	0	0	0	0	0	(3,300)	32
33	Real Estate Taxes	0	0	25	0	0	0	0	0	0	0	0	25	33
34	Rent-Facility & Grounds	0	1,695	(287,948)	0	0	0	0	0	0	0	0	(286,253)	34
35	Rent-Equipment & Vehicles	0	0	(3,085)	0	0	0	0	0	0	0	0	(3,085)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,300)	2,363	(278,547)	0	0	0	0	0	0	0	0	(279,484)	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)	(123,559)	33,702	(262,177)	0	0	0	0	0	0	0	0	(352,034)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Helia Healthcare Services	100.00%	\$ 997	\$ 997	1
2	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	18,232	15,232	2
3	V	19 Professional Services		Helia Healthcare Services	100.00%	1,399	1,399	3
4	V	21 Clerical & General Office		Helia Healthcare Services	100.00%	587	587	4
5	V	22 Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	6,787	6,787	5
6	V	25 Admin Staff Transportation		Helia Healthcare Services	100.00%	5,422	5,422	6
7	V	26 Insurance		Helia Healthcare Services	100.00%	915	915	7
8	V	30 Depreciation		Helia Healthcare Services	100.00%	668	668	8
9	V	34 Rent - Facility & Grounds		Helia Healthcare Services	100.00%	1,695	1,695	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,000			\$ 36,702	\$ * 33,702	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:

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 214	\$	214	15
16	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	13,070		13,070	16
17	V	17 Administrative	254,200	Bridgemark Healthcare, LLC	100.00%	56,087		(198,113)	17
18	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	4,705		4,705	18
19	V	20 Dues, Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	384		384	19
20	V	21 Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	158,692		158,692	20
21	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,026		24,026	21
22	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,230		5,230	22
23	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,668		5,668	23
24	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	2,490		2,490	24
25	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	3,545		3,545	25
26	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	25		25	26
27	V	34 Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	8,892		8,892	27
28	V	34 Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	951		951	28
29	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	209		209	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%	4		4	34
35	V	30 Depreciation		Bridgemark Medical Supply	100.00%	675		675	35
36	V	34 Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	159		159	36
37	V	35 Equipment Rental	3,294	Bridgemark Medical Supply	100.00%			(3,294)	37
38	V								38
39	Total		\$ 560,444			\$ 298,267	\$ *	(262,177)	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: 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	537,610	4.72	9.45	Distribution	\$ 56,087	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	\$ 56,087		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:

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 NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Resident Days	248,320	10	\$ 2,267	\$ 23,459	\$ 214	1	
2	10	Nursing & Medical Records	Resident Days	248,320	10	138,347	138,347	23,459	13,070	2
3	17	Owners Compensation	Resident Days	248,320	10	593,697	23,459	56,087	56,087	3
4	19	Professional Fees	Resident Days	248,320	10	49,802	23,459	4,705	4,705	4
5	20	Dues, Subscriptions	Resident Days	248,320	10	4,062	23,459	384	384	5
6	21	Salaries - Other	Resident Days	248,320	10	1,347,083	1,347,083	23,459	127,260	6
7	21	Clerical & Office Supplies	Resident Days	248,320	10	332,712	23,459	31,432	31,432	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	248,320	10	254,317	23,459	24,026	24,026	8
9	24	Seminars	Resident Days	248,320	10	55,362	23,459	5,230	5,230	9
10	25	Admin Staff Travel	Resident Days	248,320	10	60,000	23,459	5,668	5,668	10
11	26	Insurance	Resident Days	248,320	10	26,357	23,459	2,490	2,490	11
12	30	Depreciation	Resident Days	248,320	10	37,526	23,459	3,545	3,545	12
13	33	Real Estate Taxes	Resident Days	248,320	10	261	23,459	25	25	13
14	34	Building Rent	Resident Days	248,320	10	94,122	23,459	8,892	8,892	14
15	34	Rental - Storage Unit	Resident Days	248,320	10	10,067	23,459	951	951	15
16	35	Equipment Rental	Resident Days	248,320	10	2,216	23,459	209	209	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	\$ 284,188		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Revenue	12,000	4	\$ 3,989	\$ 3,000	\$ 997	1
2	6	Maintenance	Revenue	12,000	4	72,927	72,927	18,232	2
3	19	Professional Services	Revenue	12,000	4	5,597	3,000	1,399	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	2,348	3,000	587	4
5	22	Payroll Taxes & Emp. Bene.	Revenue	12,000	4	27,148	3,000	6,787	5
6	25	Other Admin Transportation	Revenue	12,000	4	21,686	3,000	5,422	6
7	26	Insurance	Revenue	12,000	4	3,659	3,000	915	7
8	30	Depreciation	Revenue	12,000	4	2,670	3,000	668	8
9	34	Rent	Revenue	12,000	4	6,780	3,000	1,695	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					\$ 146,804	\$ 72,927	\$ 36,702	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & General Office	Revenue	129,336	8	\$ 168	\$ 3,294	\$ 4	1
2	30	Depreciation	Revenue	129,336	8	26,491	3,294	675	2
3	34	Rent - Facility & Grounds	Revenue	129,336	8	6,237	3,294	159	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	\$	\$ 838	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia Healthcare of Benton

0049775

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	MidCap Funding I, LLC		X			10/22/09				Variable	24,837						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 24,837						
B. Non-Facility Related*																	
10	Interest Income		X								(3,300)						
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,300)						
15	TOTALS (line 9+line14)						\$	\$			\$ 21,537						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2013 report.	\$	129,000		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).	\$	(129,000)		3
4.	Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	19,100		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.	\$	(109,900)		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2009	_____	8	
		2010	_____	9	
		2011	See Note on	10	
		2012	Tax Statement	11	
		2013	_____	12	
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 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 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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>The parcel for this property has not been split out by the County to date.</u>		\$ _____	\$ _____
2.	<u>When the facility was owned by the Hospital, it was not assessed for real</u>		\$ _____	\$ _____
3.	<u>estate taxes. An estimate for real estate taxes was accrued by the</u>		\$ _____	\$ _____
4.	<u>provider. This has been adjusted off in the current year.</u>		\$ _____	\$ _____
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 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 Healthcare of Benton

0049775 Report Period Beginning:

01/01/14 Ending:

12/31/14

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Related Party Allocation Helia Healthcare</u>			\$ <u>1,253</u>	1
2					2
3	TOTALS			\$ <u>1,253</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Helia Healthcare Allocation	2006		\$ 7,450	\$	25	\$ 373	\$ 373	\$ 3,291	4
5	83	2008		134,098		30	4,470	4,470	28,682	5
6										6
7										7
8										8
Improvement Type**										
9										9
10	Nurse's Station	2009		1,221	81	15	81		481	10
11	Exterior Sign	2009		5,265	527	10	527		3,071	11
12	Landscaping - Disposed 2014	2009			414	10	414			12
13	Wallcovering for hallways & entranceway, doors, shower remodel	2009		11,252	750	15	750		4,001	13
14	Carpet	2009		1,170	156	5	156		1,170	14
15	Nurse's Station Remodel/Wiring	2009		2,556	170	15	170		894	15
16	New Pipes, Install Eye Wash	2010		2,215	89	25	89		407	16
17	AC, fans, dehumidifier	2010		1,609	161	10	161		724	17
18	Outside single door & frame	2010		4,168	278	15	278		1,181	18
19	Shower Room - Tile, shower heads, electrical work, fixtures, paint	2011		3,860	257	15	257		921	19
20	Dinette/Common area remodel - doors, windows, counters, cabinetry, (cont.) flooring, electrical, plywood, paint	2011		13,693	913	15	913		3,272	21
22	Back-Up Generator	2011		12,864	643	20	643		2,144	22
23	Sprinkler System	2012		97,800	3,912	25	3,912		11,736	23
24	Fire Doors	2012		9,942	663	15	663		1,878	24
25	Oxygen Shed	2012		1,941	194	10	194		469	25
26	AC Equipment North Hallway	2014		1,896	95	10	95		95	26
27	Painting 1 Room, 1/2 North Hall	2014		250	8	5	8		8	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:

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Related Party Allocation - Helia Healthcare		\$	\$		\$	\$	\$	37
38	Water & Sewer Pipe Installation	2006	475		20	24	24	200	38
39	Plumbing & Heating Installation	2006	569		20	29	29	239	39
40	A/C Unit - 4 Ton	2007	1,370		10	137	137	1,050	40
41									41
42	Related Party Allocation - Bridgemark Healthcare LLC								42
43	New Office Build-Out	2011	12,831		20	679	679	2,346	43
44	Conference Room Chair Rail & Paint	2012	145		5	29	29	68	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)		\$ 328,640	\$ 9,311		\$ 15,052	\$ 5,741	\$ 68,328	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 127,363	\$ 8,505	\$ 15,552	\$ 7,047	7	\$ 63,346	71
72	Current Year Purchases	18,580	765	1,083	318	7	1,083	72
73	Fully Depreciated Assets	14,988					14,988	73
74								74
75	TOTALS	\$ 160,931	\$ 9,270	\$ 16,635	\$ 7,365		\$ 79,417	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	\$ 1,255	\$	\$	\$	5	\$ 1,255	76
77	Related Party Allocation - Helia		2006	1,678		23	23	4	1,678	77
78	Facility	Bus	2011	28,821	7,205	7,205		4	27,020	78
79										79
80	TOTALS			\$ 31,754	\$ 7,205	\$ 7,228	\$ 23		\$ 29,953	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)	\$ 522,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,786	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,915	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,129	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 177,698	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775

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: 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

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 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 51,723

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	<u>Section N/A</u>		\$	\$	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: 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		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				182,011		182,011	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39, 2					45,891		45,891	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				661,658			661,658	13
14	TOTAL			\$		\$ 661,658	\$ 227,902		\$ 889,560	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# 0049775Report 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,999	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>53,800</u>)	762,995		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,911		7
8	Accounts Receivable (owners or related parties)	3,162,299		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,963,204	\$	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	171,702		15
16	Equipment, at Historical Cost	120,013		16
17	Accumulated Depreciation (book methods)	(93,727)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	19,100		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 217,088	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,180,292	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 752,128	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,593		30
31	Accrued Taxes Payable (excluding real estate taxes)	558		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	45,741		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 863,120	\$	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	<u>Note Payable - Owner</u>	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)	\$ 986,849	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,193,443	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,180,292	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,865,990	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,865,990	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	327,453	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)	\$ 327,453	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,193,443	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 5,012,444	1	
2	Discounts and Allowances for all Levels	(108,335)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,904,109	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	132,563	6	
7	Oxygen	7,778	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 140,341	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	956	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	572	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)	\$ 1,528	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	3,300	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,300	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Write-off over accrued Real Estate Taxes	109,900	28	
28a	Miscellaneous	3,261	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 113,161	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,162,439	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,034,930	31	
32	Health Care	1,343,598	32	
33	General Administration	1,000,836	33	
B. Capital Expense				
34	Ownership	410,138	34	
C. Ancillary Expense				
35	Special Cost Centers	889,560	35	
36	Provider Participation Fee	155,924	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,834,986	40	
41	Income before Income Taxes (line 30 minus line 40)**	327,453	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 327,453	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,577,175	44
45	Private Pay - Net Inpatient Revenue	578,821	45
46	Medicare - Net Inpatient Revenue	2,487,610	46
47	Other-(specify) <u>Insurance</u>	249,200	47
48	Other-(specify) <u>Hospice</u>	11,303	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,904,109	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 Healthcare of Benton

0049775

Report Period Beginning: 01/01/14

Ending: 12/31/14

12/31/14

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	1,922	2,044	\$ 57,238	\$ 28.00	1
2	Assistant Director of Nursing	61	61	1,514	24.82	2
3	Registered Nurses	7,209	7,532	181,494	24.10	3
4	Licensed Practical Nurses	17,439	19,008	331,338	17.43	4
5	CNAs & Orderlies	49,985	53,589	561,599	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,688	1,857	19,795	10.66	8
9	Activity Director					9
10	Activity Assistants	2,931	3,158	31,705	10.04	10
11	Social Service Workers	1,606	1,779	28,090	15.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,164	10,900	112,701	10.34	15
16	Dishwashers					16
17	Maintenance Workers	2,474	2,586	41,419	16.02	17
18	Housekeepers	8,965	9,705	84,847	8.74	18
19	Laundry	1,689	1,900	18,507	9.74	19
20	Administrator	1,811	2,037	63,660	31.25	20
21	Assistant Administrator					21
22	Other Administrative	1,379	1,446	16,615	11.49	22
23	Office Manager	1,845	2,105	39,425	18.73	23
24	Clerical	1,314	1,377	15,825	11.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,482	121,084	\$ 1,605,772 *	\$ 13.26	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	\$ 12,000	9,3	36
37	Medical Records Consultant	1,830	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,313	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	1,727	11,3	44
45	Social Service Consultant	1,727	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 19,597		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description	Amount	Description	Amount		Amount
Michelle Hensgen	Administrator	0	\$ 63,660	Workers' Compensation Insurance	\$ 70,302	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	73,321	Advertising: Employee Recruitment	11,410		
				FICA Taxes	120,207	Health Care Worker Background Check	3,148		
				Employee Health Insurance	25,751	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	4,303		
				401(k) Match	2,288	Late Fees	852		
				Employee Benefits	3,433	Miscellaneous Licenses & Fees	1,074		
				Other Employee Insurance	5,557	Related Party Allocation - Bridgemark	384		
						Advertising	34,382		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(34,382)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,660	Related Party Allocation - Bridgemark	30,813			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,161
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
Bridgemark Healthcare LLC - Management Fees			\$ 254,200						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 254,200						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
C.J. Schlosser & Company, LLC	Accounting Services		\$ 5,407	Section N/A		\$	Out-of-State Travel	\$	
Ceridian	Payroll Processing		11,895						
Kramer & Frank	Legal Fees		200						
Personnel Planners, Inc	Unemployment Consultant		2,048				In-State Travel	1,988	
MidCap	Project Loan Fees		8,692						
TransAmerica Retirement Solutions	Administration Fees		353						
							Seminar Expense	2,633	
							Related Party Allocation - Bridgemark	5,230	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 28,595	TOTAL		\$	TOTAL	\$ 9,851	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

0049775

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 \$1,647
- (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. \$ 3,768 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. \$ 155,924
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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 Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2014

<u>Description</u>		
16A	Nursing Equipment	47,339
16B	Copier Lease	4,175
16C	Related Party Allocation - Bridgemark Healthcare	209
		<u>51,723</u>