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: 0046920

Facility Name: Helia Hlthcare of Carbondale

Address: 500 Lewis Lane (Number) Carbondale (City) 62901 (Zip Code)

County: Jackson

Telephone Number: (618) 529-5355 **Fax #** (618) 529-3189

HFS ID Number:

Date of Initial License for Current Owners: 11/01/2004

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 Carbondale # 0046920 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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	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	14,481	2,658	3,443	20,582	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,481	2,658	3,443	20,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.79%

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 11/01/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2004 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 2,313

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 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 Carbondale # 0046920 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 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	122,531	14,132	7,359	144,022		144,022		144,022			1
2	Food Purchase		144,227		144,227		144,227	(92)	144,135			2
3	Housekeeping	88,657	21,806		110,463		110,463		110,463			3
4	Laundry	101	12,997	85,269	98,367		98,367		98,367			4
5	Heat and Other Utilities			101,063	101,063		101,063	(6,509)	94,554			5
6	Maintenance	36,842	26,987	65,451	129,280		129,280	15,232	144,512			6
7	Other (specify):*											7
8	**TOTAL General Services**	248,131	220,149	259,142	727,422		727,422	8,631	736,053			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	932,741	94,546	33,043	1,060,330		1,060,330	11,467	1,071,797			10
10a	Therapy		987		987		987		987			10a
11	Activities	27,031	8,875	3,667	39,573		39,573	(1,336)	38,237			11
12	Social Services	32,781	61	2,577	35,419		35,419		35,419			12
13	CNA Training											13
14	Program Transportation			1,062	1,062		1,062		1,062			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	992,553	104,469	70,349	1,167,371		1,167,371	10,131	1,177,502			16
	C. General Administration											
17	Administrative	66,423		174,300	240,723		240,723	(125,091)	115,632			17
18	Directors Fees											18
19	Professional Services			28,821	28,821		28,821	5,527	34,348			19
20	Dues, Fees, Subscriptions & Promotions			74,246	74,246		74,246	(46,698)	27,548			20
21	Clerical & General Office Expenses	45,043	24,563	84,321	153,927		153,927	111,355	265,282			21
22	Employee Benefits & Payroll Taxes			242,914	242,914		242,914	27,866	270,780			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,053	7,053		7,053	4,589	11,642			24
25	Other Admin. Staff Transportation			13,225	13,225		13,225	10,395	23,620			25
26	Insurance-Prop.Liab.Malpractice			69,942	69,942		69,942	3,100	73,042			26
27	Other (specify):*											27
28	**TOTAL General Administration**	111,466	24,563	694,822	830,851		830,851	(8,957)	821,894			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,352,150	349,181	1,024,313	2,725,644		2,725,644	9,805	2,735,449			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 Carbondale #0046920 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			28,518	28,518		28,518	5,742	34,260			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,203	80,203		80,203	(12,150)	68,053			32
33	Real Estate Taxes			73,482	73,482		73,482	22	73,504			33
34	Rent-Facility & Grounds			318,789	318,789		318,789	10,792	329,581			34
35	Rent-Equipment & Vehicles			34,229	34,229		34,229	(9,405)	24,824			35
36	Other (specify):*											36
37	**TOTAL Ownership**			535,221	535,221		535,221	(4,999)	530,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,154	327,388	506,542		506,542		506,542			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,550	174,550		174,550		174,550			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		179,154	501,938	681,092		681,092		681,092			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,352,150	528,335	2,061,472	3,941,957		3,941,957	4,806	3,946,763			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 Carbondale # 0046920 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	(1,336)	11		4
5	Telephone, TV & Radio in Resident Rooms	(7,694)	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	(12,150)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	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	(475)	20		17
18	Fines and Penalties	(18,350)	21		18
19	Entertainment	(9,674)	21		19
20	Contributions	(450)	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	(37,692)	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	(8,868)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,781)		$	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)	101,587	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 101,587		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 4,806		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

STATE OF ILLINOIS **Page 5A**

Helia Hlthcare of Carbondale

ID# **0046920**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (7,409)	20	1
2	Eliminate Lobbying & PAC Dues	(1,459)	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**	(8,868)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Carbondale **#** 0046920 **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	(92)	0	0	0	0	0	0	0	0	0	0	(92)	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	(7,694)	997	188	0	0	0	0	0	0	0	0	(6,509)	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**	(7,786)	16,229	188	0	0	0	0	0	0	0	0	8,631	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	11,467	0	0	0	0	0	0	0	0	11,467	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,336)	0	0	0	0	0	0	0	0	0	0	(1,336)	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**	(1,336)	0	11,467	0	0	0	0	0	0	0	0	10,131	16
	C. General Administration													
17	Administrative	0	0	(125,091)	0	0	0	0	0	0	0	0	(125,091)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,399	4,128	0	0	0	0	0	0	0	0	5,527	19
20	Fees, Subscriptions & Promotions	(47,035)	0	337	0	0	0	0	0	0	0	0	(46,698)	20
21	Clerical & General Office Expenses	(28,474)	587	139,242	0	0	0	0	0	0	0	0	111,355	21
22	Employee Benefits & Payroll Taxes	0	6,787	21,079	0	0	0	0	0	0	0	0	27,866	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,589	0	0	0	0	0	0	0	0	4,589	24
25	Other Admin. Staff Transportation	0	5,422	4,973	0	0	0	0	0	0	0	0	10,395	25
26	Insurance-Prop.Liab.Malpractice	0	915	2,185	0	0	0	0	0	0	0	0	3,100	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(75,509)	15,110	51,442	0	0	0	0	0	0	0	0	(8,957)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,631)	31,339	63,097	0	0	0	0	0	0	0	0	9,805	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	668	5,074	0	0	0	0	0	0	0	0	5,742	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,150)	0	0	0	0	0	0	0	0	0	0	(12,150)	32
33	Real Estate Taxes	0	0	22	0	0	0	0	0	0	0	0	22	33
34	Rent-Facility & Grounds	0	1,695	9,097	0	0	0	0	0	0	0	0	10,792	34
35	Rent-Equipment & Vehicles	0	0	(9,405)	0	0	0	0	0	0	0	0	(9,405)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,150)	2,363	4,788	0	0	0	0	0	0	0	0	(4,999)	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)**	(96,781)	33,702	67,885	0	0	0	0	0	0	0	0	4,806	45

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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 Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Helia Healthcare Services	100.00%	$ 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		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 Hlthcare of Carbondale # 0046920 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 Carbondale # 0046920 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	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 188	$ 188	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	11,467	11,467	16
17	V	17	Administrative	174,300	Bridgemark Healthcare, LLC	100.00%	49,209	(125,091)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	4,128	4,128	18
19	V	20	Dues, Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	337	337	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	139,230	139,230	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	21,079	21,079	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,589	4,589	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,973	4,973	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,185	2,185	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	3,110	3,110	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	22	22	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	8,635	8,635	27
28	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	184	184	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	21	Clerical & General Office Expenses		Bridgemark Medical Supply	100.00%	12	12	34
35	V	30	Depreciation		Bridgemark Medical Supply	100.00%	1,964	1,964	35
36	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	462	462	36
37	V	35	Equipment Rental	9,589	Bridgemark Medical Supply	100.00%		(9,589)	37
38	V								38
39	Total			$ 183,889			$ 251,774	$ * 67,885	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 Carbondale # 0046920 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	544,488	4.14	8.29	Distribution	$ 49,209	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	$ 49,209		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 Carbondale # 0046920 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	$	20,582	$ 188	1
2	10	Nursing & Medical Records	Resident Days	248,320	10	138,347	138,347	20,582	11,467	2
3	17	Owners Compensation	Resident Days	248,320	10	593,697		20,582	49,209	3
4	19	Professional Fees	Resident Days	248,320	10	49,802		20,582	4,128	4
5	20	Dues, Subscriptions	Resident Days	248,320	10	4,062		20,582	337	5
6	21	Salaries - Other	Resident Days	248,320	10	1,347,083	1,347,083	20,582	111,653	6
7	21	Clerical & Office Supplies	Resident Days	248,320	10	332,712		20,582	27,577	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	248,320	10	254,317		20,582	21,079	8
9	24	Seminars	Resident Days	248,320	10	55,362		20,582	4,589	9
10	25	Admin Staff Travel	Resident Days	248,320	10	60,000		20,582	4,973	10
11	26	Insurance	Resident Days	248,320	10	26,357		20,582	2,185	11
12	30	Depreciation	Resident Days	248,320	10	37,526		20,582	3,110	12
13	33	Real Estate Taxes	Resident Days	248,320	10	261		20,582	22	13
14	34	Building Rent	Resident Days	248,320	10	94,122		20,582	7,801	14
15	34	Rental - Storage Unit	Resident Days	248,320	10	10,067		20,582	834	15
16	35	Equipment Rental	Resident Days	248,320	10	2,216		20,582	184	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		$ 249,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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: Helia Healthcare Services
Street Address: 308 Mcleansboro Street
City / State / Zip Code: Benton, IL 62812
Phone Number: (618) 435-3304
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	5	Utilities	Revenue	12,000	4	$ 3,989	$	3,000	$ 997	1
2	6	Maintenance	Revenue	12,000	4	72,927	72,927	3,000	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 Hlthcare of Carbondale # 0046920 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 & General Office	Revenue	129,336	8	$ 168	$	9,589	$ 12	1
2	30	Depreciation	Revenue	129,336	8	26,491		9,589	1,964	2
3	34	Rent	Revenue	129,336	8	6,237		9,589	462	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	$		$ 2,438	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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	Line of Credit		10/22/09				Variable	80,203	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 80,203	9
	B. Non-Facility Related*											
10	Interest Income		X								(12,150)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,150)	14
15	TOTALS (line 9+line14)						$	$			$ 68,053	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 Carbondale **#** 0046920 **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.**	$	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.)		$ 73,482	2
3. Under or (over) accrual (line 2 minus line 1).		$ 73,482	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 73,482	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	61,442	8
	2010	68,079	9
	2011	70,002	10
	2012	73,219	11
	2013	74,797	12

73,482 Line 7, Real Estate Tax Portion of Lease Payments
22 Bridgemark Healthcare Allocation
73,504 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 Carbondale COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0046920

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.	15-22-326-010	Long Term Care	$ 74,796.72	$ 74,796.72
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,796.72	$ 74,796.72

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 Carbondale # 0046920 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Masonry Frame Wood 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 [ ] (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	Related Party Allocation Helia Healthcare			$ 1,253	1
2					2
3	TOTALS			$ 1,253	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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	Related Party Allocation - Helia Healthcare				$ 7,450	$		$ 372	$ 372	$ 3,291	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Concrete			2005	1,575	157	10	157		1,469	10
11	Nurses Station & Med Room			2005	20,510	2,051	10	2,051		18,630	11
12	Weatherproof Lights			2006	4,719	472	10	472		4,247	12
13	3-4 ton A/C Units			2006	7,500		5			7,500	13
14	New Nurses Station			2006	2,995	299	10	299		2,546	14
15	New Sprinkler System			2007	39,969	3,997	10	3,997		30,931	15
16	Roof Repair			2007	13,608	1,361	10	1,361		10,093	16
17	Compressor			2007	1,672	167	10	167		1,226	17
18	Front Building Sign			2007	1,271	127	10	127		964	18
19	Lowes - Tile			2008	738	74	10	74		498	19
20	Installed Sims 232 Card			2008	1,106	111	10	111		738	20
21	Roof Replacement			2008	14,548	1,455	10	1,455		8,971	21
22	Ceiling Tiles			2008	1,308	131	10	131		796	22
23	Fire Protection Annunciator for Front			2008	1,111	111	10	111		666	23
24	Plumbing Repair/Water Heater/Expansion Tank			2009	9,378	527	20	527		2,908	24
25	A/C Compressors			2009	2,489	166	15	166		913	25
26	Dry Pendent - Sprinkler System/Fire Equipment			2010	5,353	437	15	437		2,109	26
27	405 ton air handler			2010	3,000	150	20	150		725	27
28	New Locks			2010	770	110	7	110		523	28
29	Tear out existing pad and repour concrete			2010	2,500	167	15	167		778	29
30	20 KW Power Generator			2010	9,750	1,950	5	1,950		8,613	30
31	Biohazard Shed			2010	1,649	165	10	165		756	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 Hlthcare of Carbondale # 0046920 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	Kitchen Remodel/C-Hall Renovation/Roof Repair	2011	$ 3,211	$ 214	15	$ 214	$	$ 827	37
38	4 A/C Units	2011	2,567	513	5	513		1,754	38
39	Hot Water Heater	2011	5,920	592	10	592		2,121	39
40	Wireless Network System	2012	2,205	441	5	441		1,250	40
41	Secure Care Model Wander System	2012	2,336	234	10	234		643	41
42	3 PTAC Units	2012	1,617	162	10	162		431	42
43	New Heat Pump & Dust System	2012	9,143	914	10	914		2,285	43
44	New Roof Top Unit	2012	5,032	503	10	503		1,258	44
45	Flooring Tile for Dinning Room in West/Upper Side of Facility	2012	8,908	891	10	891		2,153	45
46	PTAC Unit	2012	1,140	114	10	114		257	46
47	Heat Pump	2012	1,119	112	10	112		243	47
48	A/C Unit & Air Handler	2012	1,163	116	10	116		281	48
49	Privacy Fence	2013	10,084	1,261	8	1,261		2,311	49
50	2 Uplink Wires	2013	6,756	338	20	338		619	50
51	Windows	2013	302	20	15	20		23	51
52	GE Stoneline A/C Unit	2013	947	189	5	189		284	52
53	2 PTAC Units	2013	1,284	257	5	257		364	53
54	Data Cabling Access Points	2014	6,233	467	10	467		467	54
55	CTS - Additional Wiring	2014	1,647	82	10	82		82	55
56	Frigidaire PTAC	2014	1,261	21	5	21		21	56
57	HD - Vinyl Flooring	2014	420	14	10	14		14	57
58	Indoff - Frigidaire heating cooling	2014	679	45	5	45		45	58
59									59
60	Related Party Allocation - Helia Healthcare								60
61	Water & Sewer Pipe Installation	2006	475		20	24	24	200	61
62	Plumbing & Heating Installation	2006	569		20	29	29	239	62
63	A/C Unit - 4 ton	2007	1,370		10	137	137	1,050	63
64									64
65									65
66	Related Party Allocation - Bridgemark Healthcare								66
67	New Office Build-Out	2011	11,257		20	596	596	2,059	67
68	Conference Room Chair Rail & Paint	2012	127		5	25	25	59	68
69									69
70	TOTAL (lines 4 thru 69)		$ 242,741	$ 21,685		$ 22,868	$ 1,183	$ 131,231	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 Carbondale # 0046920 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	$ 66,061	$ 5,022	$ 9,220	$ 4,198	5-15	$ 37,040	71
72	Current Year Purchases	21,791	1,811	2,149	338	5-15	2,149	72
73	Fully Depreciated Assets	58,738					58,738	73
74								74
75	TOTALS	$ 146,590	$ 6,833	$ 11,369	$ 4,536		$ 97,927	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	Bus	2008	$ 7,995	$	$	$	4	$ 7,995	76
77	Facility	Truck	2008	5,250				4	5,250	77
78	Related Party Allocation - Bridgemark			1,101				4	1,101	78
79	Related Party Allocation - Helia			1,678		23	23	4	1,678	79
80	TOTALS			$ 16,024	$	$ 23	$ 23		$ 16,024	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)	$ 406,608	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,518	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,260	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,742	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 245,182	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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: Ridgeway Associates, 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:		118		$ 318,789			3
4	Additions							4
5								5
6	Related Party Allocations				10,792			6
7	TOTAL		118		$ 329,581 **			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 [ ] NO

16. Rental Amount for movable equipment: $ 24,824 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 Carbondale # 0046920 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 Carbondale # 0046920 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs				987		987	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				114,682		114,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					64,472		64,472	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				327,388			327,388	13
14	TOTAL			$		$ 327,388	$ 180,141		$ 507,529	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 Carbondale # 0046920 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	$ 382	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,200)	707,971		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,199		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	500		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 710,052	$	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	205,522		15
16	Equipment, at Historical Cost	130,814		16
17	Accumulated Depreciation (book methods)	(208,899)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 127,437	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 837,489	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 482,087	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,798		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,009		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessments	15,811		36
37	Due to Bridgemark Healthcare	2,228,896		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,769,601	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	147,431		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 147,431	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,917,032	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,079,543)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 837,489	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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**	$ (1,611,005)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,611,005)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(468,538)	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)**	$ (468,538)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,079,543)	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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	$ 3,443,110	1
2	Discounts and Allowances for all Levels	(82,805)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,360,305	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,710	6
7	Oxygen	13,406	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 96,116	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	1,336	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,795	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,131	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,150	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,150	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	1,717	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,717	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,473,419	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	727,422	31
32	Health Care	1,167,371	32
33	General Administration	830,851	33
	B. Capital Expense		
34	Ownership	535,221	34
	C. Ancillary Expense		
35	Special Cost Centers	506,542	35
36	Provider Participation Fee	174,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,941,957	40
41	**Income before Income Taxes (line 30 minus line 40)****	(468,538)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (468,538)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,683,882	44
45	Private Pay - Net Inpatient Revenue	460,458	45
46	Medicare - Net Inpatient Revenue	821,812	46
47	Other-(specify) Insurance	365,538	47
48	Other-(specify) Hospice	28,615	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,360,305	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 Carbondale # 0046920 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	1,980	2,121	$ 70,040	$ 33.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,001	6,291	149,961	23.84	3
4	Licensed Practical Nurses	15,179	16,277	306,323	18.82	4
5	CNAs & Orderlies	36,731	38,285	406,417	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,964	2,082	27,031	12.98	10
11	Social Service Workers	1,998	2,135	32,781	15.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,247	11,598	122,531	10.56	15
16	Dishwashers					16
17	Maintenance Workers	1,913	2,000	36,842	18.42	17
18	Housekeepers	8,771	9,285	88,657	9.55	18
19	Laundry	12	12	101	8.42	19
20	Administrator	2,063	2,122	66,423	31.30	20
21	Assistant Administrator					21
22	Other Administrative	262	497	15,825	31.84	22
23	Office Manager	1,378	1,462	29,218	19.98	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	89,499	94,167	$ 1,352,150 *	$ 14.36	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,359	1,3	35
36	Medical Director		30,000	9,3	36
37	Medical Records Consultant		2,725	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,109	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		3,667	11,3	44
45	Social Service Consultant		2,577	12,3	45
46	Other(specify)				46
47	Psych Consultant		6,000	10,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 54,437		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janet Squibb	Administrator	0	$ 66,423
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 66,423

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 174,300
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 174,300

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 5,407
Ceridian	Payroll Processing	10,755
Personnel Planners, Inc	Unemployment Consultant	2,673
TransAmerica Retirement Solutions	Retirement Admin Fees	352
Much Shelist	Legal Fees - Disciplinary Action	9,634
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 28,821

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,224
Unemployment Compensation Insurance	59,330
FICA Taxes	102,177
Employee Health Insurance	15,429
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	1,479
Employee Benefits	2,871
Other Employee Insurance	2,404
Related Party Allocation - Bridgemark	21,079
Related Party Allocation - Helia	6,787
TOTAL (agree to Schedule V, line 22, col.8)	$ 270,780

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	12,515
Health Care Worker Background Check	6,976
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	4,376
Late Fees	1,184
Miscellaneous Licenses & Fees	170
Related Party Allocation - Bridgemark	337
Advertising	37,692
Less: Public Relations Expense	( )
Non-allowable advertising	(37,692)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,548

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,816
Seminar Expense	4,237
Related Party Allocation - Bridgemark	4,589
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,642

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Carbondale # 0046920 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 Carbondale # 0046920 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 $2,341**

(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. $ **11,330** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **174,550**
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? **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? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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. $ **No**

(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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Carbondale
Attachment to Schedule XII B
Equipment Rentals
12/31/2014

	Description	
16A	Nursing Equipment	14,577
16B	Copier Lease	10,063
16C	Related Party Allocation - Bridgemark Healthcare	184
		24,824