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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049775

Facility Name: Helia Healthcare of Benton

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

County: Franklin

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

HFS ID Number:

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

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 01/01/15 to 12/31/15 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 Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,535	5,778	5,393	23,706	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,535	5,778	5,393	23,706	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.25%

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 08/15/08

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 4,225

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: 12/31/15 Fiscal Year: 12/31/15

* 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: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	97,149	11,750	169,260	278,159		278,159		278,159			1
2	Food Purchase		273,068		273,068		273,068	(59)	273,009			2
3	Housekeeping	89,271	30,022	100	119,393		119,393		119,393			3
4	Laundry	10,585	17,841	115,008	143,434		143,434		143,434			4
5	Heat and Other Utilities			85,611	85,611		85,611	(3,346)	82,265			5
6	Maintenance	47,771	24,579	54,256	126,606		126,606	3,869	130,475			6
7	Other (specify):*											7
8	TOTAL General Services	244,776	357,260	424,235	1,026,271		1,026,271	464	1,026,735			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,136,961	81,222	27,196	1,245,379		1,245,379	12,436	1,257,815			10
10a	Therapy		356		356		356		356			10a
11	Activities	33,276	11,794	2,052	47,122		47,122	(1,252)	45,870			11
12	Social Services	34,095		1,575	35,670		35,670		35,670			12
13	CNA Training											13
14	Program Transportation			2,129	2,129		2,129		2,129			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,204,332	93,372	44,952	1,342,656		1,342,656	11,184	1,353,840			16
	C. General Administration											
17	Administrative	72,272		237,000	309,272		309,272	(215,598)	93,674			17
18	Directors Fees											18
19	Professional Services			19,467	19,467		19,467	5,772	25,239			19
20	Dues, Fees, Subscriptions & Promotions			79,416	79,416		79,416	(58,616)	20,800			20
21	Clerical & General Office Expenses	73,079	20,150	65,199	158,428		158,428	124,230	282,658			21
22	Employee Benefits & Payroll Taxes			279,421	279,421		279,421	33,069	312,490			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,099	2,099		2,099	4,748	6,847			24
25	Other Admin. Staff Transportation			7,118	7,118		7,118	14,961	22,079			25
26	Insurance-Prop.Liab.Malpractice			70,183	70,183		70,183	2,634	72,817			26
27	Other (specify):*											27
28	TOTAL General Administration	145,351	20,150	759,903	925,404		925,404	(88,800)	836,604			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,594,459	470,782	1,229,090	3,294,331		3,294,331	(77,152)	3,217,179			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 Healthcare of Benton #0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			21,480	21,480		21,480	12,027	33,507			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,431	35,431		35,431	(31)	35,400			32
33	Real Estate Taxes			21,000	21,000		21,000	(20,595)	405			33
34	Rent-Facility & Grounds			303,088	303,088		303,088	(288,232)	14,856			34
35	Rent-Equipment & Vehicles			42,553	42,553		42,553	(2,696)	39,857			35
36	Other (specify):*											36
37	TOTAL Ownership			423,552	423,552		423,552	(299,527)	124,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		186,363	572,223	758,586		758,586		758,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,713	151,713		151,713		151,713			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		186,363	723,936	910,299		910,299		910,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,594,459	657,145	2,376,578	4,628,182		4,628,182	(376,679)	4,251,503			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: 01/01/15 Ending: 12/31/15

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	(1,252)	11		4
5	Telephone, TV & Radio in Resident Rooms	(4,784)	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	(31)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	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				18
19	Entertainment	(5,474)	21		19
20	Contributions	(2,119)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(49,138)	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	(10,196)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,209)		$	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)	(303,470)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (303,470)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (376,679)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Benton

ID# 0049775

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (8,280)	20	1
2	Eliminate Lobbying & PAC Dues	(1,857)	20	2
3	Eliminate Medical Record Copies	(59)	10	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**	(10,196)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(59)	0	0	0	0	0	0	0	0	0	0	(59)	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	(4,784)	48	1,390	0	0	0	0	0	0	0	0	(3,346)	5
6	Maintenance	0	0	3,869	0	0	0	0	0	0	0	0	3,869	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,843)	48	5,259	0	0	0	0	0	0	0	0	464	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	(59)	12,495	0	0	0	0	0	0	0	0	0	12,436	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,252)	0	0	0	0	0	0	0	0	0	0	(1,252)	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**	(1,311)	12,495	0	0	0	0	0	0	0	0	0	11,184	16
	C. General Administration													
17	Administrative	0	(215,598)	0	0	0	0	0	0	0	0	0	(215,598)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6)	5,152	626	0	0	0	0	0	0	0	0	5,772	19
20	Fees, Subscriptions & Promotions	(59,425)	809	0	0	0	0	0	0	0	0	0	(58,616)	20
21	Clerical & General Office Expenses	(7,593)	130,896	927	0	0	0	0	0	0	0	0	124,230	21
22	Employee Benefits & Payroll Taxes	0	24,740	8,329	0	0	0	0	0	0	0	0	33,069	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,748	0	0	0	0	0	0	0	0	0	4,748	24
25	Other Admin. Staff Transportation	0	7,003	7,958	0	0	0	0	0	0	0	0	14,961	25
26	Insurance-Prop.Liab.Malpractice	0	1,459	1,175	0	0	0	0	0	0	0	0	2,634	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(67,024)	(40,791)	19,015	0	0	0	0	0	0	0	0	(88,800)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,178)	(28,248)	24,274	0	0	0	0	0	0	0	0	(77,152)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Benton # 0049775 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	2,221	9,806	0	0	0	0	0	0	0	0	12,027	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31)	0	0	0	0	0	0	0	0	0	0	(31)	32
33	Real Estate Taxes	0	19	(20,614)	0	0	0	0	0	0	0	0	(20,595)	33
34	Rent-Facility & Grounds	0	7,267	(295,499)	0	0	0	0	0	0	0	0	(288,232)	34
35	Rent-Equipment & Vehicles	0	0	(2,696)	0	0	0	0	0	0	0	0	(2,696)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(31)	9,507	(309,003)	0	0	0	0	0	0	0	0	(299,527)	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)**	(73,209)	(18,741)	(284,729)	0	0	0	0	0	0	0	0	(376,679)	45

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Champaign	Champaign, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthcare of Greenville	Greenville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 48	$ 48	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	12,495	12,495	2
3	V	17	Management Fees	237,000	Bridgemark Healthcare, LLC	100.00%	21,402	(215,598)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	5,152	5,152	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	809	809	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	130,896	130,896	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,740	24,740	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,748	4,748	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	7,003	7,003	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,459	1,459	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,221	2,221	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	19	19	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,267	7,267	13
14	Total			$ 237,000			$ 218,259	$ * (18,741)	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: 01/01/15 Ending: 12/31/15

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	35	Equipement Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 589	$ 589	15
16	V								16
17	V	21	Clerical & Office Supplies		Bridgemark Medical Supply	100.00%	19	19	17
18	V	30	Depreciation		Bridgemark Medical Supply	100.00%	565	565	18
19	V	34	Building Rent		Bridgemark Medical Supply	100.00%	171	171	19
20	V	35	Equipement Rental	3,285	Bridgemark Medical Supply	100.00%		(3,285)	20
21	V								21
22	V	5	Utilities		Helia Healthcare Services	100.00%	1,390	1,390	22
23	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	6,869	3,869	23
24	V	19	Professional Services		Helia Healthcare Services	100.00%	626	626	24
25	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	908	908	25
26	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	8,329	8,329	26
27	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	7,958	7,958	27
28	V	26	Insurance		Helia Healthcare Services	100.00%	1,175	1,175	28
29	V	30	Depreciation		Helia Healthcare Services	100.00%	1,000	1,000	29
30	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	386	386	30
31	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	2,260	2,260	31
32	V								32
33	V	30	Depreciation		BM Properties I - Benton	100.00%	8,241	8,241	33
34	V	33	Real Estate Taxes	21,000	BM Properties I - Benton	100.00%		(21,000)	34
35	V	34	Rent - Facility & Grounds	302,950	BM Properties I - Benton	100.00%	5,020	(297,930)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 330,235			$ 45,506	$ * (284,729)	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: 01/01/15 Ending: 12/31/15

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			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Jerseyville	Jerseyville, IL				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	278,598	3.57	7.13	Distribution	$ 21,402	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	$ 21,402		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: 01/01/15 Ending: 12/31/15

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	332,289	13	$ 671	$	23,706	$ 48	1
2	10	Nursing & Medical Records	Resident Days	332,289	13	175,140	175,140	23,706	12,495	2
3	17	Owners Compensation	Resident Days	332,289	13	300,000		23,706	21,402	3
4	19	Professional Fees	Resident Days	332,289	13	72,214		23,706	5,152	4
5	20	Dues, Subscriptions	Resident Days	332,289	13	11,333		23,706	809	5
6	21	Salaries - Other	Resident Days	332,289	13	1,491,031	1,491,031	23,706	106,372	6
7	21	Clerical & Office Supplies	Resident Days	332,289	13	343,761		23,706	24,524	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	332,289	13	346,778		23,706	24,740	8
9	24	Seminars	Resident Days	332,289	13	66,551		23,706	4,748	9
10	25	Admin Staff Travel	Resident Days	332,289	13	98,168		23,706	7,003	10
11	26	Insurance	Resident Days	332,289	13	20,457		23,706	1,459	11
12	30	Depreciation	Resident Days	332,289	13	31,136		23,706	2,221	12
13	33	Real Estate Taxes	Resident Days	332,289	13	263		23,706	19	13
14	34	Building Rent	Resident Days	332,289	13	94,122		23,706	6,715	14
15	34	Rental - Storage Unit	Resident Days	332,289	13	7,741		23,706	552	15
16	35	Equipment Rental	Resident Days	332,289	13	8,255		23,706	589	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,067,621	$ 1,666,171		$ 218,848	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & Office Supplies	Revenue	119,851	7	$ 679	$	3,285	$ 19	1
2	30	Depreciation	Revenue	119,851	7	20,624		3,285	565	2
3	34	Building Rent	Revenue	119,851	7	6,237		3,285	171	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					$ 27,540	$		$ 755	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 St
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	9,000	3	$ 4,169	$	3,000	$ 1,390	1
2	6	Maintenance	Revenue	9,000	3	20,606	20,606	3,000	6,869	2
3	19	Professional Services	Revenue	9,000	3	1,879		3,000	626	3
4	21	Clerical & Office Supplies	Revenue	9,000	3	2,723		3,000	908	4
5	22	Payroll Taxes & Emp Benefits	Revenue	9,000	3	24,986		3,000	8,329	5
6	25	Other Admin Transportation	Revenue	9,000	3	23,874		3,000	7,958	6
7	26	Insurance	Revenue	9,000	3	3,526		3,000	1,175	7
8	30	Depreciation	Revenue	9,000	3	3,001		3,000	1,000	8
9	33	Real Estate Taxes	Revenue	9,000	3	1,159		3,000	386	9
10	34	Rent	Revenue	9,000	3	6,780		3,000	2,260	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					$ 92,703	$ 20,606		$ 30,901	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	35,431	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 35,431	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(31)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (31)	14
15	TOTALS (line 9+line14)						$	$			$ 35,400	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 19,100	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).		$ (19,100)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 21,069	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.		$ 1,969	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
2010			8
2011			9
2012	See Note on		10
2013	Tax Statement		11
2014			12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	The parcel for this property has not been split out by the County to date.		$	$
2.	When the facility was owned by the Hospital, it was not assessed for real		$	$
3.	estate taxes. An estimate for real estate taxes was accrued by the		$	$
4.	provider. This has been adjusted off in the prior year.		$	$
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation - Helia Healthcare			$ 1,670	1
2					2
3	TOTALS			$ 1,670	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Helia Healthcare Allocation		2006		$ 9,933	$	25	$ 497	$ 497	$ 4,884	4
5	83		2008		134,098		30	4,470	4,470	33,152	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		562	9
10	Exterior Sign			2009	5,265	527	10	527		3,598	10
11	Wallcovering for hallways & entranceway, doors, shower remodel			2009	11,252	750	15	750		4,751	11
12	Carpet			2009	1,170		5			1,170	12
13	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		1,064	13
14	New Pipes, Install Eye Wash			2010	2,215	89	25	89		496	14
15	AC, Fans, dehumidifier			2010	1,609	161	10	161		885	15
16	Outside singe door & frame			2010	4,168	278	15	278		1,459	16
17	Shower room - tile, shower heads, electrical work, fixtures, paint			2011	3,860	257	15	257		1,178	17
18	Dinette/Common area remodel - doors, windows, counters, cabinetry										18
19	(cont.) flooring, electrical, plywood, paint			2011	13,693	913	15	913		4,185	19
20	Back-Up generator			2011	12,864	643	20	643		2,787	20
21	Sprinkler System			2012	97,800	3,912	25	3,912		15,648	21
22	Fire Doors			2012	9,942	663	15	663		2,541	22
23	Oxygen Shed			2012	1,941	194	10	194		663	23
24	AC Equipment North Hallway			2014	1,896	190	10	190		285	24
25	Painting 1 room, 1/2 North Hall			2014	250	50	5	50		58	25
26	Therapy Remodel - flooring, painting, & lighting			2015	4,045	180	15	180		180	26
27	Vinyl Sliding Door & Installation			2015	5,325	148	15	148		148	27
28	Flooring in North hall rooms and hallway			2015	7,282	162	15	162		162	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation - Bridgemark HealthcareLLC		$	$		$	$	$	37
38	New Office Build-Out	2011	9,689		20	513	513	2,285	38
39	Conference Room Chair Rail & Paint	2012	110		5	22	22	73	39
40									40
41									41
42	Related Party Allocation - Helia Healthcare								42
43	Water & Sewer Pipe Installation	2006	633		20	32	32	298	43
44	Plumbing & Heating Installation	2006	758		20	38	38	357	44
45	A/C Unit - 4 Ton	2007	1,827		10	183	183	1,583	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)		$ 345,402	$ 9,368		$ 15,123	$ 5,755	$ 84,452	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 136,283	$ 9,594	$ 15,839	$ 6,245	7	$ 71,497	71
72	Current Year Purchases	10,644	717	744	27	7	744	72
73	Fully Depreciated Assets	24,318					24,318	73
74								74
75	TOTALS	$ 171,245	$ 10,311	$ 16,583	$ 6,272		$ 96,559	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	2011	$ 28,821	$ 1,801	$ 1,801	$	4	$ 28,821	76
77	Related Party Allocation - Bridgemark		2005	948				4	948	77
78	Related Party Allocation - Helia		2006	2,237				4	2,237	78
79										79
80	TOTALS			$ 32,006	$ 1,801	$ 1,801	$		$ 32,006	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)	$ 550,323	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,480	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,507	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,027	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 213,017	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: 01/01/15 Ending: 12/31/15

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	Storage Rental				138			5
6	Related Party Allocations				14,718			6
7	TOTAL				$ 14,856 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 39,857 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				356		356	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				155,950		155,950	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					30,412		30,412	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				572,223			572,223	13
14	TOTAL			$		$ 572,223	$ 186,718		$ 758,941	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 Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 2,624	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 53,079)	787,355		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	29,027		7
8	Accounts Receivable (owners or related parties)	2,722,912		8
9	Other(specify): Deposits	100		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,542,018	$	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	188,354		15
16	Equipment, at Historical Cost	130,129		16
17	Accumulated Depreciation (book methods)	(115,206)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	40,100		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	19,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 262,877	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,804,895	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 874,640	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,146		30
31	Accrued Taxes Payable (excluding real estate taxes)	655		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,069		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	11,846		36
37	Accrued Expenses	9,686		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 972,042	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	123,729		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 123,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,095,771	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,709,124	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,804,895	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,193,443	1
2	Restatements (describe):		2
3	**Prior Year Adjustment to Accrued Property Taxes**	(90,199)	3
4	**Prior Year Adjustment to Workers Comp Audit**	(408,613)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,694,631	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,493	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)**	$ 14,493	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)**	$ 2,709,124	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,531,116	1
2	Discounts and Allowances for all Levels	(80,175)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,450,941	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	185,766	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 185,766	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	1,252	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133	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)**	$ 1,385	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	4,493	28
28a	Medical Record Copies	59	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,552	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,642,675	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,026,271	31
32	Health Care	1,342,656	32
33	General Administration	925,404	33
	B. Capital Expense		
34	Ownership	423,552	34
	C. Ancillary Expense		
35	Special Cost Centers	758,586	35
36	Provider Participation Fee	151,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,628,182	40
41	**Income before Income Taxes (line 30 minus line 40)****	14,493	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 14,493	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,465,313	44
45	Private Pay - Net Inpatient Revenue	761,899	45
46	Medicare - Net Inpatient Revenue	1,918,700	46
47	Other-(specify) Insurance	224,992	47
48	Other-(specify) Hospice	80,037	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,450,941	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: 01/01/15 Ending: 12/31/15

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	1,668	1,851	$ 58,486	$ 31.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,774	10,321	253,386	24.55	3
4	Licensed Practical Nurses	15,218	16,331	289,823	17.75	4
5	CNAs & Orderlies	46,671	49,931	523,770	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	965	1,042	11,496	11.03	8
9	Activity Director					9
10	Activity Assistants	2,795	2,953	33,276	11.27	10
11	Social Service Workers	1,939	2,101	34,095	16.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,002	8,644	97,149	11.24	15
16	Dishwashers					16
17	Maintenance Workers	2,750	2,804	47,771	17.04	17
18	Housekeepers	9,125	9,889	89,271	9.03	18
19	Laundry	942	1,193	10,585	8.87	19
20	Administrator	1,921	2,112	72,272	34.22	20
21	Assistant Administrator					21
22	Other Administrative	326	430	5,100	11.86	22
23	Office Manager	2,072	2,215	44,241	19.97	23
24	Clerical	1,807	1,938	23,738	12.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,975	113,755	$ 1,594,459 *	$ 14.02	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		$		35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		1,832	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,358	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		2,052	11,3	44
45	Social Service Consultant		1,575	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,817		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 Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Killgrove	Administrator	0	$ 42,159
Loretta Ellis	Administrator	0	30,113
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,272

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 237,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 237,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,206
Paycom Payroll, LLC	Payroll Processing	10,205
Personnel Planners, Inc.	Unemployment Consulting	1,748
Much Shelist	review discharge notice	468
Ashman & Stein	notice of defaults	119
Kramer & Frank	collection fees	6
HK Payroll Services	WOTC Program	2,715
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 19,467

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,430
Unemployment Compensation Insurance	59,779
FICA Taxes	120,004
Employee Health Insurance	24,205
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,227
Employee Benefits	6,301
Other Employee Insurance	1,475
Related Party Allocation - Bridgemark	24,740
Related Party Allocation - Helia Healthcare	8,329
TOTAL (agree to Schedule V, line 22, col.8)	$ 312,490

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,537
Health Care Worker Background Check	2,904
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	7,457
Late Fees	1,677
Miscellaneous Licenses & Fees	426
Advertising	49,138
Related Party Allocation - Bridgemark	809
Less: Public Relations Expense	( )
Non-allowable advertising	(49,138)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,800

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	500
Seminar Expense	1,599
Related Party Allocation - Bridgemark	4,748
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,847

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Healthcare of Benton # 0049775 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 $3,123**

(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. $ **12,459** 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. $ **151,713**
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? **Yes** Indicate the amount. $ **1,252**

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

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2015

	Description	
16A	Nursing Equipment	34,814
16B	Copier Lease	4,454
16C	Related Party Allocation - Bridgemark Healthcare	589
		39,857