

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0046920 Facility Name: Helia Healthcare of Carbondale Address: 500 Lewis Lane Carbondale 62901 County: Jackson Telephone Number: (618) 529-5355 Fax #: (618) 529-3189 HFS ID Number: Date of Initial License for Current Owners: 11/01/04 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Cindy A. Tefteller Telephone Number: (618)465-7717 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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) (Type or Print Name) Michael Parentin (Title) Chief Financial Officer (Signed) See Accountant's Compilation Report (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 Paid Preparer 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
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SEE ACCOUNTANTS' COMPILATION REPORT

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

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>118</u>	Skilled (SNF)	<u>118</u>	<u>43,188</u>	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	<u>118</u>	TOTALS	<u>118</u>	<u>43,188</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,083</u>	<u>3,895</u>	<u>5,088</u>	<u>22,066</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,083</u>	<u>3,895</u>	<u>5,088</u>	<u>22,066</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 51.09%

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?

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/04

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 11/01/04NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 118 and days of care provided 4,430Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	106,518	20,299	8,215	135,032		135,032		135,032		1
2	Food Purchase		134,047		134,047		134,047	(117)	133,930		2
3	Housekeeping	117,609	22,710		140,319		140,319		140,319		3
4	Laundry	2,044	16,043	104,110	122,197		122,197		122,197		4
5	Heat and Other Utilities			98,451	98,451		98,451	(5,069)	93,382		5
6	Maintenance	38,602	26,985	40,400	105,987		105,987	16,523	122,510		6
7	Other (specify):*										7
8	TOTAL General Services	264,773	220,084	251,176	736,033		736,033	11,337	747,370		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	977,500	79,771	14,925	1,072,196		1,072,196	6,810	1,079,006		10
10a	Therapy		887		887		887		887		10a
11	Activities	36,247	8,361	2,678	47,286		47,286	(1,060)	46,226		11
12	Social Services	49,274	349	2,679	52,302		52,302		52,302		12
13	CNA Training										13
14	Program Transportation			4,086	4,086	12,193	16,279		16,279		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,063,021	89,368	36,368	1,188,757	12,193	1,200,950	5,750	1,206,700		16
	C. General Administration										
17	Administrative	80,579		206,900	287,479		287,479	(180,105)	107,374		17
18	Directors Fees										18
19	Professional Services			32,039	32,039		32,039	10,242	42,281		19
20	Dues, Fees, Subscriptions & Promotions			65,566	65,566		65,566	(44,334)	21,232		20
21	Clerical & General Office Expenses	37,127	16,862	71,283	125,272		125,272	117,410	242,682		21
22	Employee Benefits & Payroll Taxes			289,664	289,664		289,664	33,322	322,986		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,015	3,015		3,015	2,778	5,793		24
25	Other Admin. Staff Transportation			16,547	16,547	(12,193)	4,354	9,985	14,339		25
26	Insurance-Prop.Liab.Malpractice			22,739	22,739		22,739	1,337	24,076		26
27	Other (specify):*										27
28	TOTAL General Administration	117,706	16,862	707,753	842,321	(12,193)	830,128	(49,365)	780,763		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,445,500	326,314	995,297	2,767,111		2,767,111	(32,278)	2,734,833		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,126	27,126		27,126	5,495	32,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,359	93,359		93,359	6,400	99,759			32
33	Real Estate Taxes			71,649	71,649		71,649	3,090	74,739			33
34	Rent-Facility & Grounds			349,803	349,803		349,803	10,219	360,022			34
35	Rent-Equipment & Vehicles			24,698	24,698		24,698	239	24,937			35
36	Other (specify):*											36
37	TOTAL Ownership			566,635	566,635		566,635	25,443	592,078			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		345,133	435,007	780,140		780,140		780,140			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,322	221,322		221,322		221,322			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		345,133	656,329	1,001,462		1,001,462		1,001,462			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,445,500	671,447	2,218,261	4,335,208		4,335,208	(6,835)	4,328,373			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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,060)	11		4
5	Telephone, TV & Radio in Resident Rooms	(7,168)	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	19	30		9
10	Interest and Other Investment Income	(4,993)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(117)	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				17
18	Fines and Penalties	(19,115)	21		18
19	Entertainment	(10,142)	21		19
20	Contributions	(1,137)	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	(37,130)	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	(8,006)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (88,849)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	82,014	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 82,014		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,835)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0046920
Report Period Beginning: 01/01/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Gifts & Flowers	\$ (5,758)	20	1
2	Eliminate Lobbying & PAC Dues	(1,745)	20	2
3	Offset Medical Records Income	(503)	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	(8,006)		49

STATE OF ILLINOIS

Summary A

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

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	(117)	0	0	0	0	0	0	0	0	0	0	(117)	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	(7,168)	1,812	287	0	0	0	0	0	0	0	0	(5,069)	5
6	Maintenance	0	16,523	0	0	0	0	0	0	0	0	0	16,523	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,285)	18,335	287	0	0	0	0	0	0	0	0	11,337	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	(503)	0	7,313	0	0	0	0	0	0	0	0	6,810	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,060)	0	0	0	0	0	0	0	0	0	0	(1,060)	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	(1,563)	0	7,313	0	0	0	0	0	0	0	0	5,750	16
	C. General Administration													
17	Administrative	0	0	(180,105)	0	0	0	0	0	0	0	0	(180,105)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	784	9,458	0	0	0	0	0	0	0	0	10,242	19
20	Fees, Subscriptions & Promotions	(44,633)	0	299	0	0	0	0	0	0	0	0	(44,334)	20
21	Clerical & General Office Expenses	(30,394)	1,221	146,583	0	0	0	0	0	0	0	0	117,410	21
22	Employee Benefits & Payroll Taxes	0	7,932	25,390	0	0	0	0	0	0	0	0	33,322	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,778	0	0	0	0	0	0	0	0	2,778	24
25	Other Admin. Staff Transportation	0	5,236	4,749	0	0	0	0	0	0	0	0	9,985	25
26	Insurance-Prop.Liab.Malpractice	0	287	1,050	0	0	0	0	0	0	0	0	1,337	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(75,027)	15,460	10,202	0	0	0	0	0	0	0	0	(49,365)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(83,875)	33,795	17,802	0	0	0	0	0	0	0	0	(32,278)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	19	1,733	3,743	0	0	0	0	0	0	0	0	5,495	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,993)	8,792	2,601	0	0	0	0	0	0	0	0	6,400	32
33	Real Estate Taxes	0	3,000	90	0	0	0	0	0	0	0	0	3,090	33
34	Rent-Facility & Grounds	0	1,650	8,569	0	0	0	0	0	0	0	0	10,219	34
35	Rent-Equipment & Vehicles	0	0	239	0	0	0	0	0	0	0	0	239	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,974)	15,175	15,242	0	0	0	0	0	0	0	0	25,443	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(88,849)	48,970	33,044	0	0	0	0	0	0	0	0	(6,835)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 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%	\$ 1,812	\$ 1,812	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	19,523	16,523	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	784	784	3
4	V	21	Clerical & Office Expenses		Helia Healthcare Services	100.00%	1,221	1,221	4
5	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	7,932	7,932	5
6	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	5,236	5,236	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	287	287	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	1,733	1,733	8
9	V	32	Interest		Helia Healthcare Services	100.00%	8,792	8,792	9
10	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,000	3,000	10
11	V	34	Rent		Helia Healthcare Services	100.00%	1,650	1,650	11
12	V								12
13	V								13
14	Total			\$ 3,000			\$ 51,970	\$ * 48,970	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 287	\$ 287	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	7,313	7,313	16
17	V	17	Management Fees	206,900	Bridgemark Healthcare, LLC	100.00%	26,795	(180,105)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	9,458	9,458	18
19	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	299	299	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	146,583	146,583	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	25,390	25,390	21
22	V	24	Travel & Seminars		Bridgemark Healthcare, LLC	100.00%	2,778	2,778	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,749	4,749	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,050	1,050	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	3,743	3,743	25
26	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	2,601	2,601	26
27	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	90	90	27
28	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	8,569	8,569	28
29	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	239	239	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 206,900			\$ 239,944	\$ * 33,044	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	309,830	3.98	7.96	Distribution	\$ 26,795	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	\$ 26,795		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

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	277,215	11	\$ 3,605	\$	22,066	\$ 287	1
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	22,066	7,313	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625		22,066	26,795	3
4	19	Professional Fees	Resident Days	277,215	11	118,827		22,066	9,458	4
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754		22,066	299	5
6	21	Salaries - Other	Resident Days	277,215	11	1,345,667	1,345,667	22,066	107,114	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853		22,066	39,469	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977		22,066	25,390	8
9	24	Seminars	Resident Days	277,215	11	34,902		22,066	2,778	9
10	25	Admin Staff Travel	Resident Days	277,215	11	59,659		22,066	4,749	10
11	26	Insurance	Resident Days	277,215	11	13,196		22,066	1,050	11
12	30	Depreciation	Resident Days	277,215	11	47,028		22,066	3,743	12
13	32	Interest	Resident Days	277,215	11	32,681		22,066	2,601	13
14	33	Real Estate Taxes	Resident Days	277,215	11	1,133		22,066	90	14
15	34	Building Rent	Resident Days	277,215	11	103,521		22,066	8,240	15
16	34	Rental - Storage Unit	Resident Days	277,215	11	4,139		22,066	329	16
17	35	Equipment Rental		277,215	11	3,007		22,066	239	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,014,441	\$ 1,437,534		\$ 239,944	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09					Variable	93,359	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 93,359	9
	B. Non-Facility Related*												
10	Interest Income		X									(4,993)	10
11	Related Party Allocation - Bridgemark Healthcare											2,601	11
12	Related Party Allocation - Helia Healthcare											8,792	12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ 6,400	14
15	TOTALS (line 9+line14)						\$		\$			\$ 99,759	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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.)		\$	71,649	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	71,649	3	
4. Real Estate Tax accrual used for 2012 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.		\$	71,649	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	58,933	8	
		2008	60,911	9	
		2009	61,442	10	
		2010	68,079	11	
		2011	70,002	12	
71,649 Line 7, Real Estat Tax portion of Lease Payments					
90 Bridgemark Healthcare Allocation					
3,000 Helia Healthcare Allocation					
74,739 Total Schedule V, Line 33					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2011 \$	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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Helia Healthcare of Carbondale</u>	COUNTY	<u>Jackson</u>
---------------	---------------------------------------	--------	----------------

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 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	15-22-326-010	Long Term Care	\$ 70,001.74	\$ 70,001.74
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 70,001.74	\$ 70,001.74

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Related Party Allocation-Helia Healthcare</u>			<u>\$ 1,250</u>	1
2					2
3	TOTALS			<u>\$ 1,250</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 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	\$		\$ 373	\$ 373	\$ 2,546	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Concrete		2005	1,575	157	10	157		1,155	9
10		Fire Sprinkler		2005	2,070		5			2,070	10
11		Nurses Station & Med Room		2005	20,510	2,051	10	2,051		14,528	11
12		Exterior Sign		2005	319		5			319	12
13		Cubicle Curtains		2005	1,432		3			1,432	13
14		Door Signs		2005	512		3			512	14
15		Weatherproof Lights		2006	4,719	472	10	472		3,303	15
16		Phone Lines		2006	1,001		5			1,001	16
17		3-4 Ton A/C Units		2006	7,500		5			7,500	17
18		New Nurses Station		2006	2,995	300	10	300		1,947	18
19		New Sprinkler System		2007	39,969	3,997	10	3,997		22,938	19
20		Roof Repair		2007	13,608	1,361	10	1,361		7,371	20
21		Compressor		2007	1,672	167	10	167		892	21
22		Front Building Sign		2007	1,271	127	10	127		710	22
23		Lowes-Tile		2008	738	74	10	74		350	23
24		Installed Sims 232 Card		2008	1,106	111	10	111		516	24
25		Roof Replacement		2008	14,548	1,455	10	1,455		6,062	25
26		Ceiling Tiles		2008	1,308	131	10	131		534	26
27		Fire Protection Annunciator for Front		2008	1,111	111	10	111		444	27
28		Plumbing Repair/Water Heater/Expansion Tank		2009	9,378	527	20	527		1,854	28
29		A/C Compressors		2009	2,489	166	15	166		581	29
30		Dry Pendent - Sprinkler System/Fire Equipment		2010	5,353	437	15	437		1,235	30
31		4-5 ton air handler		2010	3,000	150	20	150		425	31
32		New Locks		2010	770	110	7	110		303	32
33		Tear out existing pad and repour concrete		2010	2,500	167	15	167		444	33
34		20 KW Power Generator		2010	9,750	1,950	5	1,950		4,713	34
35		Biohazard Shed		2010	1,649	165	10	165		426	35
36		Kitchen Remodel/C-Hall Renovation/Roof Repair		2011	3,211	223	15	214	(9)	400	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

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	4 A/C Units	2011	\$ 2,567	\$ 513	5	\$ 513	\$	\$ 727	37
38	Hot Water Heater	2011	5,920	707	10	592	(115)	937	38
39	Wireless Network System	2012	2,205	367	5	367		367	39
40	Secure Care Model wander system	2012	2,336	175	10	175		175	40
41	3 PTAC units	2012	1,617	108	10	108		108	41
42	New heat pump & dust system	2012	9,143	457	10	457		457	42
43	New Roof Top Unit	2012	5,032	252	10	252		252	43
44	Floring Tile for dining room in West/Upper side of facility	2012	8,908	371	10	371		371	44
45	PTAC Unit	2012	1,140	28	10	28		28	45
46	Heat Pump	2012	1,119	19	10	19		19	46
47	A/C Unit & Air Handler	2012	1,163	48	10	48		48	47
48									48
49	Related Party Allocation - Helia Healthcare								49
50	Water & Sewer Pipe Installation	2006	475		20	24	24	153	50
51	Plumbing & Heating Installation	2006	569		20	28	28	183	51
52	A/C Unit - 4 Ton	2007	1,370		10	137	137	776	52
53									53
54									54
55	Related Party Allocation - Bridgemark Healthcare								55
56	New Office Build-Out	2011	10,811		20	572	572	832	56
57	Conference Rm Chair Rail & Paint	2012	122		5	8	8	8	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)		\$ 218,011	\$ 17,454		\$ 18,472	\$ 1,018	\$ 91,952	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$66,361	\$7,603	\$11,272	\$3,669		\$40,082	71
72	Current Year Purchases	6,515	304	567	263		567	72
73	Fully Depreciated Assets	58,918					58,918	73
74								74
75	TOTALS	\$131,794	\$7,907	\$11,839	\$3,932		\$99,567	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	\$999	\$999	\$	4	\$7,995	76
77	Facility	Truck	2008	5,250	766	766		4	5,250	77
78	Related Party Allocation - Bridgemark			1,058		264	264	5	948	78
79	Related Party Allocation - Helia			1,678		281	281	5	1,373	79
80	TOTALS			\$15,981	\$1,765	\$2,310	\$545		\$15,566	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)	\$367,036	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$27,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$32,621	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$5,495	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$207,085	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	Schedule 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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Ridgeway Accociates, 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. ☒ 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		\$ 349,803			3
4	Additions							4
5	Related Party Allocation-Bridgemark				8,569			5
6	Related Party Allocation - Helia				1,650			6
7	TOTAL		118		\$ 360,022			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A.
- N/A

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

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 24,937 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

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.	<u>/2013</u>	\$ _____
13.	<u>/2014</u>	\$ _____
14.	<u>/2015</u>	\$ _____

* 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

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

HFS 3745 (N-4-99)

IL478-2471

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	10a,3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs				887		887	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				241,165		241,165	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Eeneral	39,2					103,968		103,968	12
13	Physical, Occupational & Speech Ther Other (specify): X-Ray & Lab	39,3				435,007			435,007	13
14	TOTAL			\$		\$ 435,007	\$ 346,020		\$ 781,027	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number	Helia Healthcare of Carbondale
--------------------------------------	---------------------------------------

0046920

Report Period Beginning: 01/01/12

Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

_____ (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	\$ 2,112	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 75,192)	951,920		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,267		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)	\$ 956,799	\$	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	179,240		15
16	Equipment, at Historical Cost	138,628		16
17	Accumulated Depreciation (book methods)	(185,044)		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)	\$ 132,824	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,089,623	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 669,078	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,414		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,770		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	Due To Bridgemark Healthcare	1,198,134		36
37	Accrued Provider Assessment	63,434		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,022,830	\$	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)	\$ 2,170,261	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,080,638)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,089,623	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (927,484)	1
2	Restatements (describe):		2
3			3
4	Prior Year Depreciation Adjustment	(19)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (927,503)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(153,135)	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)	\$ (153,135)	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)	\$ (1,080,638)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,071,795	1
2	Discounts and Allowances for all Levels	(62,500)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,009,295	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,082	6
7	Oxygen	37,049	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 166,131	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	1,060	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,060	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,993	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,993	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	503	28
28a	Miscellaneous	91	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,182,073	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	736,033	31
32	Health Care	1,188,757	32
33	General Administration	842,321	33
B. Capital Expense			
34	Ownership	566,635	34
C. Ancillary Expense			
35	Special Cost Centers	780,140	35
36	Provider Participation Fee	221,322	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,335,208	40
41	Income before Income Taxes (line 30 minus line 40)**	(153,135)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (153,135)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,494,448	44
45	Private Pay - Net Inpatient Revenue	528,038	45
46	Medicare - Net Inpatient Revenue	1,823,697	46
47	Other-(specify) Insurance	145,983	47
48	Other-(specify) Hospice	17,129	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,009,295	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,092	2,337	\$ 76,058	\$ 32.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,128	6,402	146,641	22.91	3
4	Licensed Practical Nurses	16,072	17,276	316,545	18.32	4
5	CNAs & Orderlies	41,424	43,160	429,022	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	779	921	9,234	10.03	8
9	Activity Director					9
10	Activity Assistants	3,485	3,553	36,247	10.20	10
11	Social Service Workers	2,281	2,341	49,274	21.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,840	11,358	106,518	9.38	15
16	Dishwashers					16
17	Maintenance Workers	2,001	2,153	38,602	17.93	17
18	Housekeepers	11,958	12,355	117,609	9.52	18
19	Laundry	220	227	2,044	9.00	19
20	Administrator	2,309	2,544	80,579	31.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,835	1,961	37,127	18.93	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)	101,424	106,588	\$ 1,445,500 *	\$ 13.56	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 8,215	1,3	35
36	Medical Director		12,000	9,3	36
37	Medical Records Consultant		6,891	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,034	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		2,678	11,3	44
45	Social Service Consultant		2,679	12,3	45
46	Other(specify)				46
47	Psych Consultant		6,000	10,3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,497		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Marla Fourez	Administrator	0	\$ 33,037
Ashley Barrett	Administrator	0	47,542
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,579
B. Administrative - Other			
Description			Amount
Bridgemark Healthcare LLC-Management Fees			\$ 206,900
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 206,900
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company, LLC	Accounting Services		\$ 4,025
Ceridian	Payroll Processing		10,309
Personnel Planners	Unemployment Consulting		2,503
Craig & Craig	Legal Fees		1,571
Much Shelist	Legal Fees		13,631
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 32,039
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 59,899
Unemployment Compensation Insurance			96,763
FICA Taxes			108,178
Employee Health Insurance			14,023
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401(k) Match			1,328
Employee Benefits			4,617
Uniforms			1,943
Other Employee Insurance			2,913
Related Party Allocation-Bridgemark			25,390
Related Party Allocation-Helia			7,932
TOTAL (agree to Schedule V, line 22, col.8)			\$ 322,986
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			6,458
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			5,370
Dues & Subscriptions			3,948
Late Fees			2,399
Miscellaneous Licenses & Fees			768
Related Party Allocation-Bridgemark			299
Advertising			37,130
Less: Public Relations Expense			()
Non-allowable advertising			(37,130)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 21,232
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			1,207
Seminar Expense			1,808
Related Pary Allocation-Bridgemark			2,778
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,793

*** Attach copy of IMRF notifications**
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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

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 \$2,385

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5-10 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

8,908

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.

\$

221,322

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.

(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.

\$

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

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

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Carbondale
Attachment to Schedule XII B
Equipment Rentals
12/31/2012

Description		
16A	Nursing Equipment	\$ 18,425
16B	Dietary Equipment	948
16C	Copier Lease	5,325
16D	Related Party Allocation - Bridgemark	239
		<u>\$ 24,937</u>

Helia Healthcare of Carbondale

Name of Employee Attending	Job Title	Date	Location	Seminar Title	Seminar Sponsor	Seminar Cost
Janet Squibb, Kay Squibb	SSD, AD	03/15/12	Video Course	3/15/12 Seminar	Outcome Services of IL	170
Ashley Barrett	ADM	05/07/12	Carterville, IL	CEU Training	Egyptian AAA	10
Catherine Lewis	DM	05/31/12	Online	Dietary Manager course	North Dakota	500
Kay Squibb	AD	07/01/12	Springfield, IL	Activity Education	Outcome Services of IL	88
Ashley Barrett, Janet Squib	ADM,SSD	07/31/12	Springfield, IL	Annual Coalition Meeting	Illinois Pioneer Colalition	329
Ashley B, Janet S, Melony Dalby	ADM, SSD, DON	08/23/12	Carterville, IL	CEU Training	Egyptian AAA	30
Chelsie Nosalik	DM	10/23/12	Online	DB Boot Camp training	Outcome Services of IL	125
Jessica	AD	10/31/12	Video Course	OSI - registration for act dir course	Outcome Services of IL	450
		02/02/12		Food Sanitation Certificate	Illinois Dept of Public Health	35
					On-Demand online courses	70
					Travel - Hotels	1,179
					Travel - Parking	28
					Home office allocation	2,778
					Schedule V, Line 24	<u>5,793</u>

Helia Healthcare of Carbondale

Name of Employee	Job Title	Date	Location	Description	Amount
Attending					
Kay Squibb	Activity Director	02/21/12	Breese, IL	mileage reimb for meeting	176
Yvonne Fourez	Administrator	02/23/12	Cape Girardeau	mileage reimb OSF & Landmark	67
Kay Squibb	Activity Director	02/24/12	Breese, IL	mileage reimb for meeting	176
Kay Squibb	Activity Director	03/05/12	Breese, IL	mileage reimb for meeting	176
Janet Squibb	Social Services Director	03/05/12	various	mileage reimbursement	100
Janet Squibb	Social Services Director	04/04/12	various	mileage reimbursement	92
Kathelyn Thompson	Business Office Manager	04/05/12	various	mileage reimbursement	26
Ashley Barrett	Administrator	04/10/12	various	mileage reimbursement	69
Yvonne Fourez	Administrator	04/13/12	various	mileage reimbursement	254
Kristen Howard	MDS Coordinator	05/15/12	Benton, IL	mileage reimbursement	39
Ashley Barrett	Administrator	05/15/12	Springfield, IL	mileage reimbursement	173
Janet Squibb	Social Services Director	06/07/12	various	mileage reimbursement	72
Yvonne Fourez	Administrator	07/01/12	various	mileage reimbursement	117
Jasmine Rutherford	C.N.A.	07/12/12	various	mileage reimbursement	12
Darenda Everage	C.N.A.	07/12/12	various	mileage reimbursement	20
Justeen Franklin	L.P.N.	07/12/12	various	mileage reimbursement	24
Samantha Venturelli	L.P.N.	07/12/12	various	mileage reimbursement	10
Lannie Ellis	L.P.N.	07/12/12	various	mileage reimbursement	20
Mary Emmons	L.P.N.	07/12/12	various	mileage reimbursement	76
Jim Jones	Maintenance Supervisor	08/20/12	various	mileage reimbursement	55
Mary Emmons	L.P.N.	08/20/12	various	mileage reimbursement	21
Lannie Ellis	L.P.N.	08/20/12	various	mileage reimbursement	18
Rachael Hooker	L.P.N.	08/20/12	various	mileage reimbursement	14
Darenda Everage	C.N.A.	08/20/12	various	mileage reimbursement	14
Stacy Young	Activity Director	09/04/12	various	mileage reimbursement	53
Janet Squibb	Social Services Director	09/07/12	various	mileage reimbursement	234
Ashley Barrett	Administrator	09/22/12	various	mileage reimbursement	142
Chelsey Nosalik	Dietary Manager	09/24/12	various	mileage reimbursement	215
Jim Jones	Maintenance Supervisor	10/01/12	various	mileage reimbursement	121
Ashley Barrett	Administrator	10/06/12	Carbondale	Employee appreciation outing	43
Ashley Barrett	Administrator	10/06/12	various	mileage reimbursement	59
Ashley Barrett	Administrator	10/06/12	Carbondale	Lunch for Employees working over	27
Jim Jones	Maintenance Supervisor	10/08/12	Belleville	mileage reimbursement	200
Karen Bowles	MDS Coordinator	10/15/12	Springfield, IL	mileage reimbursement	224
Ashley Barrett	Administrator	10/22/12	various	mileage reimbursement	255
Blake Squibb	Hskp/Laundry Supervisor	10/23/12	various	mileage reimbursement	96
Jim Jones	Maintenance Supervisor	10/29/12	various	mileage reimbursement	99

Shaye Taylor	C.N.A.	11/14/12	various	mileage reimbursement	18
Ashley Barrett	Administrator	11/19/12	various	mileage reimbursement	13
Ashley Barrett	Administrator	12/01/12	various	mileage reimbursement	84
Janet Squibb	Social Services Director	12/04/12	various	mileage reimbursement	47
Ashley Barrett	Administrator	12/22/12	various	mileage reimbursement	73
Rhonda Wilkes	Interim D.O.N.	12/31/12	various	mileage reimbursement	530
Costs for the van for transportation of residents - need to reclass to line 14					12,193
Home office allocation - Bridgemark					4,749
Home office allocation - Helia					5,236
Schedule V, Line 25					<u>26,532</u>