

		FOR BHF USE				

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**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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

<p><b>I. IDPH License ID Number:</b> <u>0046920</u></p> <p><b>Facility Name:</b> <u>Helia Healthcare of Carbondale</u></p> <p><b>Address:</b> <u>500 Lewis Lane</u> <u>Carbondale</u> <u>62901</u>          Number City Zip Code</p> <p><b>County:</b> <u>Jackson</u></p> <p><b>Telephone Number:</b> <u>(618) 529-5355</u> Fax # <u>(618) 529-3189</u></p> <p><b>HFS ID Number:</b> <u>371384562</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>11/01/04</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Cindy A. Tefeller</u> <b>Telephone Number:</b> <u>(618) 465-7717</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/08</u> to <u>12/31/08</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) <u>Michael Parentin</u></td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td rowspan="4" style="width: 20%;"><b>Paid Preparer</b></td> <td>(Signed) <u>See Accountants' Compilation Report</u></td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) <u>Cindy A. Tefeller</u></td> </tr> <tr> <td colspan="2">(Firm Name &amp; Address) <u>C.J. Schlosser &amp; Company, LLC</u> <u>233 E. Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE          ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>Michael Parentin</u>			(Title) <u>Chief Financial Officer</u>		<b>Paid Preparer</b>	(Signed) <u>See Accountants' Compilation Report</u>	(Date) _____	(Print Name and Title) <u>Cindy A. Tefeller</u>		(Firm Name & Address) <u>C.J. Schlosser &amp; Company, LLC</u> <u>233 E. Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale

# 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	11,994	5,081	5,559	22,634	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,994	5,081	5,559	22,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.41%

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)  
N/A

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/04

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/04 NO

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 5,183

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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
<b>A. General Services</b>											
1	Dietary	120,070	24,835	6,460	151,365		151,365		151,365		1
2	Food Purchase		135,669		135,669		135,669	(162)	135,507		2
3	Housekeeping	56,076	21,480		77,556		77,556		77,556		3
4	Laundry	23,010	13,218		36,228		36,228	3,464	39,692		4
5	Heat and Other Utilities			149,166	149,166		149,166	(4,849)	144,317		5
6	Maintenance	27,595	5,650	41,891	75,136		75,136	(2,687)	72,449		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>226,751</b>	<b>200,852</b>	<b>197,517</b>	<b>625,120</b>		<b>625,120</b>	<b>(4,234)</b>	<b>620,886</b>		8
<b>B. Health Care and Programs</b>											
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	931,928	52,030	3,999	987,957		987,957	10,902	998,859		10
10a	Therapy		1,155	509,117	510,272		510,272		510,272		10a
11	Activities	31,716	10,039	1,977	43,732		43,732		43,732		11
12	Social Services	26,484	929	3,644	31,057		31,057		31,057		12
13	CNA Training										13
14	Program Transportation			1,589	1,589		1,589		1,589		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>990,128</b>	<b>64,153</b>	<b>528,726</b>	<b>1,583,007</b>		<b>1,583,007</b>	<b>10,902</b>	<b>1,593,909</b>		16
<b>C. General Administration</b>											
17	Administrative	58,141		202,517	260,658		260,658	(184,820)	75,838		17
18	Directors Fees										18
19	Professional Services			14,661	14,661		14,661	2,888	17,549		19
20	Dues, Fees, Subscriptions & Promotions			37,234	37,234		37,234	(13,009)	24,225		20
21	Clerical & General Office Expenses	35,937	16,392	50,864	103,193		103,193	71,804	174,997		21
22	Employee Benefits & Payroll Taxes			224,949	224,949		224,949	18,556	243,505		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,785	1,785		1,785	455	2,240		24
25	Other Admin. Staff Transportation			7,490	7,490		7,490	9,811	17,301		25
26	Insurance-Prop.Liab.Malpractice			110,431	110,431		110,431	1,180	111,611		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>94,078</b>	<b>16,392</b>	<b>649,931</b>	<b>760,401</b>		<b>760,401</b>	<b>(93,135)</b>	<b>667,266</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,310,957</b>	<b>281,397</b>	<b>1,376,174</b>	<b>2,968,528</b>		<b>2,968,528</b>	<b>(86,467)</b>	<b>2,882,061</b>		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 &amp; ID Number

Helia Healthcare of Carbondale

#0046920

Report Period Beginning:

01/01/08

Ending:

12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			26,408	26,408		26,408	1,558	27,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,959	31,959		31,959	(1,573)	30,386			32
33	Real Estate Taxes			67,971	67,971		67,971	275	68,246			33
34	Rent-Facility & Grounds			294,030	294,030		294,030	6,674	300,704			34
35	Rent-Equipment & Vehicles			74,992	74,992		74,992	233	75,225			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			495,360	495,360		495,360	7,167	502,527			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,489	30,519	264,008		264,008		264,008			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		233,489	95,301	328,790		328,790		328,790			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,310,957	514,886	1,966,835	3,792,678		3,792,678	(79,300)	3,713,378			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 Carbondale

# 0046920

Report Period Beginning: 01/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,205)	05		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	(1,655)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,266)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(162)	02		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	(300)	21		18
19	Entertainment	(4,808)	21		19
20	Contributions	(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	(9,306)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(4,114)	20		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (28,953)</b>		<b>\$</b>	<b>30</b>

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)	(50,347)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (50,347)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (79,300)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Carbondale

ID# 0046920

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Gifts and Flowers	\$ (4,114)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	<b>Total</b>	(4,114)		48
49				49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Helia Healthcare of Carbondale

# 0046920

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(162)	0	0	0	0	0	0	0	0	0	0	(162)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	3,464	0	0	0	0	0	0	0	0	0	3,464	4
5	Heat and Other Utilities	(6,205)	1,287	69	0	0	0	0	0	0	0	0	(4,849)	5
6	Maintenance	0	(2,687)	0	0	0	0	0	0	0	0	0	(2,687)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,367)</b>	<b>2,064</b>	<b>69</b>	<b>0</b>	<b>(4,234)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,266)	0	13,168	0	0	0	0	0	0	0	0	10,902	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Health Care and Programs</b>	<b>(2,266)</b>	<b>0</b>	<b>13,168</b>	<b>0</b>	<b>10,902</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	(184,820)	0	0	0	0	0	0	0	0	(184,820)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	54	2,834	0	0	0	0	0	0	0	0	2,888	19
20	Fees, Subscriptions & Promotions	(13,420)	12	399	0	0	0	0	0	0	0	0	(13,009)	20
21	Clerical & General Office Expenses	(5,245)	1,103	75,946	0	0	0	0	0	0	0	0	71,804	21
22	Employee Benefits & Payroll Taxes	0	567	17,989	0	0	0	0	0	0	0	0	18,556	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4	451	0	0	0	0	0	0	0	0	455	24
25	Other Admin. Staff Transportation	0	723	9,088	0	0	0	0	0	0	0	0	9,811	25
26	Insurance-Prop.Liab.Malpractice	0	35	1,145	0	0	0	0	0	0	0	0	1,180	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(18,665)</b>	<b>2,498</b>	<b>(76,968)</b>	<b>0</b>	<b>(93,135)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(27,298)</b>	<b>4,562</b>	<b>(63,731)</b>	<b>0</b>	<b>(86,467)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	0	336	1,222	0	0	0	0	0	0	0	0	1,558 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,655)	82	0	0	0	0	0	0	0	0	0	(1,573) 32
33	Real Estate Taxes	0	275	0	0	0	0	0	0	0	0	0	275 33
34	Rent-Facility & Grounds	0	0	6,674	0	0	0	0	0	0	0	0	6,674 34
35	Rent-Equipment & Vehicles	0	0	233	0	0	0	0	0	0	0	0	233 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(1,655)</b>	<b>693</b>	<b>8,129</b>	<b>0</b>	<b>7,167 37</b>							
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(28,953)</b>	<b>5,255</b>	<b>(55,602)</b>	<b>0</b>	<b>(79,300) 45</b>							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Stephen P. Miller</u>	<u>100%</u>	<u>See Attached</u>		<u>Helia Healthcare Services Benton</u>		<u>Laundry, Maint. Ser</u>
				<u>Bridgemark Employer Services St. Louis</u>		<u>Human Resources</u>
				<u>Bridgemark Medical Supply St. Louis</u>		<u>Medical Supplies</u>

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	4 Laundry	\$	Helia Healthcare Services	100.00%	\$ 3,464	\$ 3,464 1
2	V	5 Utilities		Helia Healthcare Services	100.00%	1,287	1,287 2
3	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	313	(2,687) 3
4	V	19 Professional Services		Helia Healthcare Services	100.00%	54	54 4
5	V	20 Dues, Fees, & Subscriptions		Helia Healthcare Services	100.00%	12	12 5
6	V	21 Clerical		Helia Healthcare Services	100.00%	1,103	1,103 6
7	V	22 Employee Benefits		Helia Healthcare Services	100.00%	567	567 7
8	V	24 Seminars		Helia Healthcare Services	100.00%	4	4 8
9	V	25 Admin Staff Travel		Helia Healthcare Services	100.00%	723	723 9
10	V	26 Insurance		Helia Healthcare Services	100.00%	35	35 10
11	V	30 Depreciation		Helia Healthcare Services	100.00%	336	336 11
12	V	32 Interest		Helia Healthcare Services	100.00%	82	82 12
13	V	33 Real Estate Taxes		Helia Healthcare Services	100.00%	275	275 13
14	Total		\$ 3,000			\$ 8,255	\$ * 5,255 14

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

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	10 Nursing & Med	\$	Bridgemark Healthcare, LLC	100.00%	\$ 13,168	\$	13,168	15
16	V	17 Management Fees	202,517	Bridgemark Healthcare, LLC	100.00%	17,697		(184,820)	16
17	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	2,834		2,834	17
18	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	399		399	18
19	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	75,946		75,946	19
20	V	22 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	17,989		17,989	20
21	V	24 Seminars		Bridgemark Healthcare, LLC	100.00%	451		451	21
22	V	25 Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	9,088		9,088	22
23	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,145		1,145	23
24	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,222		1,222	24
25	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	233		233	25
26	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	6,674		6,674	26
27	V	5 Utilities		Bridgemark Healthcare, LLC	100.00%	69		69	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 202,517			\$ 146,915	\$ *	(55,602)	39

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

Facility Name & ID Number      Helia Healthcare of Carbondale      #      0046920      Report Period Beginning:      01/01/08      Ending:      12/31/08

## 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	187,100	5	8.60	Distributions	\$ 17,697	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	\$ 17,697		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 Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing & Medical Records	Resident Days	261,924	10	\$ 152,384	\$ 152,384	22,634	\$ 13,168	1
2	17	Owners Compensation	Resident Days	261,924	10	204,797		22,634	17,697	2
3	19	Professional Fees	Resident Days	261,924	10	32,797		22,634	2,834	3
4	20	Dues, Subscriptions	Resident Days	261,924	10	4,612		22,634	399	4
5	21	Clerical	Resident Days	261,924	10	878,862	815,418	22,634	75,946	5
6	22	Employee Benefits	Resident Days	261,924	10	208,169		22,634	17,989	6
7	24	Seminars	Resident Days	261,924	10	5,223		22,634	451	7
8	25	Admin Staff Travel	Resident Days	261,924	10	105,166		22,634	9,088	8
9	26	Insurance	Resident Days	261,924	10	13,246		22,634	1,145	9
10	30	Depreciation	Resident Days	261,924	10	14,145		22,634	1,222	10
11	35	Equipment Rent	Resident Days	261,924	10	2,700		22,634	233	11
12	34	Rent	Resident Days	261,924	10	75,492		22,634	6,524	12
13	34	Rental - Storage Unit	Resident Days	261,924	10	1,731		22,634	150	13
14	5	Utilities	Resident Days	261,924	10	797		22,634	69	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,700,121	\$ 967,802		\$ 146,915	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Helia Healthcare Services  
 Street Address 308 N. Mcleansboro Street  
 City / State / Zip Code Benton, IL 62812  
 Phone Number ( 618) 435-3304  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	Laundry	Revenue	137,437	4	\$ 158,696	\$ 115,204	3,000	\$ 3,464	1
2	5	Utilities	Revenue	137,437	4	58,949		3,000	1,287	2
3	6	Maintenance	Revenue	137,437	4	14,320	10,640	3,000	313	3
4	19	Professional Services	Revenue	137,437	4	2,470		3,000	54	4
5	21	Clerical & Office Supplies	Revenue	137,437	4	50,519	46,312	3,000	1,103	5
6	22	Payroll Taxes & Emp. Ben.	Revenue	137,437	4	25,964		3,000	567	6
7	24	Travel & Seminar	Revenue	137,437	4	176		3,000	4	7
8	25	Other Admin Transp	Revenue	137,437	4	33,140		3,000	723	8
9	26	Insurance	Revenue	137,437	4	1,582		3,000	35	9
10	30	Depreciation	Revenue	137,437	4	15,395		3,000	336	10
11	32	Interest	Revenue	137,437	4	3,736		3,000	82	11
12	33	Real Estate Taxes	Revenue	137,437	4	12,579		3,000	275	12
13	20	Dues, Fees, & Subscriptions	Revenue	137,437	4	554		3,000	12	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					\$ 378,080	\$ 172,156		\$ 8,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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	
						Original	Balance					
	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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	Midwest Bank		X	Line of Credit		1/1/07					31,959	6
7												7
8	Related Party Alloc. - Helia Health										82	8
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 32,041	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income		X								(1,655)	10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (1,655)	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 30,386	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Helia Healthcare of Carbondak COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0046920

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

**A. Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of t cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-22-326-010</u>	<u>Long Term Care</u>	\$ <u>58,932.96</u>	\$ <u>58,932.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>58,932.96</u>	\$ <u>58,932.96</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2008

**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 ground (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>\$ 427</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 427</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Related Party Allocation - Helia Healthcare	2006	2006	\$ 3,512	\$	25	\$ 137	\$ 137	\$ 196	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Related Party Allocation - Helia Healthcare									9
10	Water & Sewer Pipe Installation		2006	41		20	2	2	5	10
11	Plumbing & Heating Installation		2006	50		20	2	2	6	11
12	A/C Unit - 4 Ton		2007	120		10	12	12	20	12
13	Concrete		2005	1,575	158	10	158		525	13
14	Fire Sprinkler		2005	2,070	414	5	414		1,346	14
15	Nurses Station and Med Room		2005	20,510	2,051	10	2,051		6,324	15
16	Exterior Sign		2005	319	64	5	64		229	16
17	Cubicle Curtains		2005	1,432	398	3	398		1,432	17
18	Door Signs		2005	512	156	3	156		512	18
19	Weatherproof Lights		2006	4,719	472	10	472		1,416	19
20	Phone Lines		2006	1,001	200	5	200		600	20
21	3-4 Ton A/C Units		2006	7,500	1,500	5	1,500		3,750	21
22	New Nurses Station		2006	2,995	300	10	300		749	22
23	New Sprinkler System		2007	39,969	3,997	10	3,997		6,950	23
24	Roof Repair		2007	13,608	1,361	10	1,361		1,928	24
25	Compressor		2007	1,672	167	10	167		223	25
26	Front Building Sign		2007	1,271	127	10	127		201	26
27	Lowes - Tile		2008	738	55	10	55		55	27
28	Installed Sims 232 Card		2008	1,106	74	10	74		74	28
29	Roof Replacement		2008	14,548	242	10	242		242	29
30	Ceiling Tiles		2008	1,308	11	10	11		11	30
31	Fire protection amunciator for front		2008	1,111		10				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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 121,687	\$ 11,747		\$ 11,900	\$ 153	\$ 26,794

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 Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 66,880	\$ 12,509	\$ 13,570	\$ 1,061	3-10	\$ 44,208	71
72	Current Year Purchases	12,782	606	757	151	3-10	757	72
73	Fully Depreciated Assets	1,013					1,013	73
74								74
75	TOTALS	\$ 80,675	\$ 13,115	\$ 14,327	\$ 1,212		\$ 45,978	75

D. Vehicle Depreciation (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	\$ 999	76
77	Facility	Truck	2008	5,250	547	547		4	547	77
78	Related Party Allocation - Bridgemark			1,463		170	170	5	760	78
79	Related Party Allocation - Helia			114		23	23	5	59	79
80	TOTALS			\$ 14,822	\$ 1,546	\$ 1,739	\$ 193		\$ 2,365	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)	\$ 217,611	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,408	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,966	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,558	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 75,137	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Ridgeway Associates, LLC  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO  
 If NO, see instructions.

	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		\$ 294,030			3
4	Additions						4
5							5
6	Related Party Allocation - Bridgemark			6,674			6
7	<b>TOTAL</b>	118		\$ 300,704			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2009	\$ _____
13.	/2010	\$ _____
14.	/2011	\$ _____

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 \_\_\_\_\_

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: \$ 75,225 Description: See Attached Schedule  
 (Attach a schedule detailing the breakdown of movable equipment)

\* 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.

**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	<b>TOTAL</b>		\$ _____	\$ _____	21

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

- (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.

**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)	
<b>TOTAL TRAINED</b>	

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$		\$ 212,248	\$		\$ 212,248	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			84,589			84,589	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			210,336	1,155		211,491	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				179,264		179,264	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Ray &amp; Lab</u>	39-03				30,519			30,519	12
13	Other (specify): <u>Wound Care, Oxy, Ent</u>	39-02					54,225		54,225	13
14	TOTAL			\$		\$ 537,692	\$ 234,644		\$ 772,336	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 Carbondale # 0046920 Report Period Beginning: 01/01/08 Ending: 12/31/08  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 8,153	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 54,250 )	853,090		3
4	Supply Inventory (priced at )	1,497		4
5	Short-Term Investments			5
6	Prepaid Insurance	323		6
7	Other Prepaid Expenses	1,488		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	1,436		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 865,987	\$	10
<b>B. Long-Term Assets</b>				
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	104,205		15
16	Equipment, at Historical Cost	99,316		16
17	Accumulated Depreciation (book methods)	(70,784)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 132,737	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 998,724	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 472,905	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,736		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,532		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
<b>Other Current Liabilities(specify):</b>				
36	Due to Bridgemark Healthcare	493,696		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,051,869	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	159,738		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 159,738	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,211,607	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (212,883)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 998,724	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (404,982)	1
2	Restatements (describe):		2
3	Miscellaneous	770	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (404,212)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	191,329	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)	\$ 191,329	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (212,883)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Carbondale

# 0046920

Report Period Beginning: 01/01/08

Ending:

Page 19

12/31/08

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,840,282	1
2	Discounts and Allowances for all Levels	(89,669)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,750,613	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	171,177	6
7	Oxygen	49,875	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 221,052	8
<b>C. Other Operating Revenue</b>			
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		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,655	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,655	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Attached</u>	10,687	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,687	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,984,007	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	625,120	31
32	Health Care	1,583,007	32
33	General Administration	760,401	33
<b>B. Capital Expense</b>			
34	Ownership	495,360	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	264,008	35
36	Provider Participation Fee	64,782	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,792,678	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	191,329	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 191,329	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Helia Healthcare of Carbondale

# 0046920

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	2,033	2,073	\$ 54,497	\$ 26.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,038	1,082	18,777	17.35	3
4	Licensed Practical Nurses	18,992	20,396	350,027	17.16	4
5	CNAs & Orderlies	44,567	46,822	448,367	9.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,433	3,759	31,716	8.44	10
11	Social Service Workers	2,036	2,167	26,484	12.22	11
12	Dietician					12
13	Food Service Supervisor	2,076	2,266	31,512	13.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,100	10,635	88,558	8.33	15
16	Dishwashers					16
17	Maintenance Workers	1,894	2,009	27,595	13.74	17
18	Housekeepers	6,202	6,398	56,076	8.76	18
19	Laundry	2,709	2,936	23,010	7.84	19
20	Administrator	2,080	2,080	58,141	27.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,257	2,489	35,937	14.44	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	1,642	1,690	20,328	12.03	31
32	Other Health Care MDS	1,974	2,133	39,932	18.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,033	108,935	\$ 1,310,957 *	\$ 12.03	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	157	\$ 6,460	01-03	35
36	Medical Director	Monthly	8,400	09-03	36
37	Medical Records Consultant	70	3,302	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	697	10-03	39
40	Physical Therapy Consultant	40	1,944	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	1,977	11-03	44
45	Social Service Consultant	66	3,644	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	380	\$ 26,424		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

Facility Name & ID Number Helia Healthcare of Carbondale

# 0046920

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Yolanda Fisher	Administrator	0.00%	\$ 58,141	Workers' Compensation Insurance	\$ 62,193	IDPH License Fee	\$	
				Unemployment Compensation Insurance	34,530	Advertising: Employee Recruitment	8,352	
				FICA Taxes	98,528	Health Care Worker Background Check	5,360	
				Employee Health Insurance	28,670	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,860	
				401k Match	1,028	Advertising	9,306	
				Related Party Allocation - Bridgemark	17,989	Miscellaneous licenses and fees	4,242	
				Related Party Allocation - Helia Healthcare	567	Related Party Allocation - Bridgemark	399	
						Related Party Allocation - Helia Health	12	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(9,306)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,141	TOTAL (agree to Schedule V, line 22, col.8)	\$ 243,505	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,225	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Bridgemark Healthcare LLC - Management Fees			\$ 202,517	Section N/A		\$	Out-of-State Travel	\$
							In-State Travel	864
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 202,517				Seminar Expense	921
C. Professional Services							Related Party Allocation - Bridgemark	451
Vendor/Payee	Type		Amount				Related Party Allocation - Helia Healthcare	4
Sachnoff & Weaver	Legal		\$ 4,186				Entertainment Expense	( )
Kramer & Frank	Legal		150				(agree to Sch. V, line 24, col. 8)	
FR&R Healthcare Consulting, Inc.	Accounting Services		770				TOTAL	\$ 2,240
Ceridian	Payroll Services		9,555					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 14,661	TOTAL		\$		

\* 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
				FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale# 0046920Report Period Beginning: 01/01/08Ending: 12/31/08**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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,536 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. \$ 64,782  
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 benefit: on Schedule V. \$ 0 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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) 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Helia Healthcare of Carbondale  
Attachment to Schedule VII A  
Related Nursing Homes  
12/31/2008

Helia Healthcare of Belleville  
Helia Healthcare of Benton  
Helia Healthcare of Champaign  
Helia Healthcare of Energy  
Helia Healthcare of Urbana  
Cardinal Hill Healthcare Center  
Frankfort Rehabilitation Center  
Helia Southbelt Healthcare  
Sangamon Care Center

Helia Healthcare of Carbondale  
Attachment to Schedule XVII  
Other Revenue  
12/31/2008

Description	
Medical Record Copies	\$ 252
Accounts Receivable Adjustments	8,151
Medical Supply & HS worker reimbursements	2,266
Miscellaneous	18
	<u>\$ 10,687</u>