FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049775

Facility Name: Helia Healthcare of Benton

Address: 1310 Mark Franklin Louis Street (Number) Benton (City) 62896 (Zip Code)

County: Franklin

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,928	7,092	7,963	27,983	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,928	7,092	7,963	27,983	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.37%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 8/15/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 7,338

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	104,552	7,054	113,991	225,597		225,597		225,597			1
2	Food Purchase		174,887		174,887		174,887	(219)	174,668			2
3	Housekeeping	108,164	33,535		141,699		141,699		141,699			3
4	Laundry		16,151	86,346	102,497		102,497	8,460	110,957			4
5	Heat and Other Utilities			108,220	108,220		108,220	3,127	111,347			5
6	Maintenance	25,819	16,845	42,345	85,009		85,009	8,972	93,981			6
7	Other (specify):*											7
8	TOTAL General Services	238,535	248,472	350,902	837,909		837,909	20,340	858,249			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,244,149	79,272	5,396	1,328,817		1,328,817	15,596	1,344,413			10
10a	Therapy		260	554,698	554,958		554,958		554,958			10a
11	Activities	32,482	12,094	1,813	46,389		46,389		46,389			11
12	Social Services	27,844	65	1,748	29,657		29,657		29,657			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,304,475	91,691	575,655	1,971,821		1,971,821	15,596	1,987,417			16
	C. General Administration											
17	Administrative	75,028		253,757	328,785		328,785	(227,201)	101,584			17
18	Directors Fees											18
19	Professional Services			15,000	15,000		15,000	5,909	20,909			19
20	Dues, Fees, Subscriptions & Promotions			55,890	55,890		55,890	(43,290)	12,600			20
21	Clerical & General Office Expenses	61,249	28,604	86,811	176,664		176,664	145,102	321,766			21
22	Employee Benefits & Payroll Taxes			280,868	280,868		280,868	44,939	325,807			22
23	Inservice Training & Education											23
24	Travel and Seminar							1,253	1,253			24
25	Other Admin. Staff Transportation			11,906	11,906		11,906	20,751	32,657			25
26	Insurance-Prop.Liab.Malpractice			55,412	55,412		55,412	1,808	57,220			26
27	Other (specify):*											27
28	TOTAL General Administration	136,277	28,604	759,644	924,525		924,525	(50,729)	873,796			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,679,287	368,767	1,686,201	3,734,255		3,734,255	(14,793)	3,719,462			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton #0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,736	8,736		8,736	15,298	24,034			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							21,282	21,282			32
33	Real Estate Taxes			24,000	24,000		24,000	3,489	27,489			33
34	Rent-Facility & Grounds			310,450	310,450		310,450	(294,180)	16,270			34
35	Rent-Equipment & Vehicles			69,131	69,131		69,131	270	69,401			35
36	Other (specify):*											36
37	TOTAL Ownership			412,317	412,317		412,317	(253,841)	158,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		275,788	81,343	357,131		357,131		357,131			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,443	45,443		45,443		45,443			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		275,788	126,786	402,574		402,574		402,574			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,679,287	644,555	2,225,304	4,549,146		4,549,146	(268,634)	4,280,512			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,997)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,350)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(219)	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	(185)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,420)	21		19
20	Contributions	(200)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(33,209)	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	(11,495)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,275)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(212,359)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (212,359)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (268,634)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Benton

ID# 0049775

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	TO ELIMINATE GIFTS AND FLOWERS	$ (8,456)	20	1
2	TO ELIMINATE COLLECTION FEES	(156)	21	2
3	TO ELIMINATE LOBBYING & PAC DUES	(1,888)	20	3
4	TO ELIMINATE 2011 IDPH FEES	(995)	20	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**	(11,495)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	(219)	0	0	0	0	0	0	0	0	0	0	(219)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	8,460	0	0	0	0	0	0	0	0	0	8,460	4
5	Heat and Other Utilities	(4,997)	8,124	0	0	0	0	0	0	0	0	0	3,127	5
6	Maintenance	0	8,972	0	0	0	0	0	0	0	0	0	8,972	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,216)	25,556	0	0	0	0	0	0	0	0	0	20,340	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	15,596	0	0	0	0	0	0	0	0	15,596	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	**TOTAL Health Care and Programs**	0	0	15,596	0	0	0	0	0	0	0	0	15,596	16
	C. General Administration													
17	Administrative	0	0	(227,201)	0	0	0	0	0	0	0	0	(227,201)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(200)	890	5,219	0	0	0	0	0	0	0	0	5,909	19
20	Fees, Subscriptions & Promotions	(44,733)	9	1,434	0	0	0	0	0	0	0	0	(43,290)	20
21	Clerical & General Office Expenses	(4,776)	17,794	132,084	0	0	0	0	0	0	0	0	145,102	21
22	Employee Benefits & Payroll Taxes	0	19,278	25,661	0	0	0	0	0	0	0	0	44,939	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,253	0	0	0	0	0	0	0	0	1,253	24
25	Other Admin. Staff Transportation	0	10,684	10,067	0	0	0	0	0	0	0	0	20,751	25
26	Insurance-Prop.Liab.Malpractice	0	183	1,625	0	0	0	0	0	0	0	0	1,808	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(49,709)	48,838	(49,858)	0	0	0	0	0	0	0	0	(50,729)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,925)	74,394	(34,262)	0	0	0	0	0	0	0	0	(14,793)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Benton # 0049775 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	4,587	10,711	0	0	0	0	0	0	0	0	15,298	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,350)	22,611	21	0	0	0	0	0	0	0	0	21,282	32
33	Real Estate Taxes	0	3,468	21	0	0	0	0	0	0	0	0	3,489	33
34	Rent-Facility & Grounds	0	1,272	(295,452)	0	0	0	0	0	0	0	0	(294,180)	34
35	Rent-Equipment & Vehicles	0	0	270	0	0	0	0	0	0	0	0	270	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,350)	31,938	(284,429)	0	0	0	0	0	0	0	0	(253,841)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(56,275)	106,332	(318,691)	0	0	0	0	0	0	0	0	(268,634)	45

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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
Stephen P. Miller	100%	See Attached		Bridgemark Healthcare	St. Louis	Management Co.
				Helia Health Care Services	Benton	Laundry, Maint. Ser
				Bridgemark Employer Services	St. Louis	Human Resources
				Bridgemark Medical Supply	St. Louis	Medical Supplies

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Laundry	$ 22,087	Helia Healthcare Services	100.00%	$ 30,547	$ 8,460	1
2	V	5	Utilities		Helia Healthcare Services	100.00%	8,124	8,124	2
3	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	11,972	8,972	3
4	V	19	Professional Services		Helia Healthcare Services	100.00%	890	890	4
5	V	20	Dues, Fees, & Subscriptions		Helia Healthcare Services	100.00%	9	9	5
6	V	21	Clerical		Helia Healthcare Services	100.00%	17,794	17,794	6
7	V	22	Employee Benefits		Helia Healthcare Services	100.00%	19,278	19,278	7
8	V	25	Admin Staff Travel		Helia Healthcare Services	100.00%	10,684	10,684	8
9	V	26	Insurance		Helia Healthcare Services	100.00%	183	183	9
10	V	30	Depreciation		Helia Healthcare Services	100.00%	4,587	4,587	10
11	V	32	Interest		Helia Healthcare Services	100.00%	22,611	22,611	11
12	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,468	3,468	12
13	V	34	Rent		Helia Healthcare Services	100.00%	1,272	1,272	13
14	Total			$ 25,087			$ 131,419	$ * 106,332	14

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing & Medical Records	$	Bridgemark Healthcare, L.L.C.	100.00%	$ 15,596	$ 15,596	15
16	V	17	Administrative	253,757	Bridgemark Healthcare, L.L.C.	100.00%	26,556	(227,201)	16
17	V	19	Professional Fees		Bridgemark Healthcare, L.L.C.	100.00%	5,219	5,219	17
18	V	20	Dues, Subscriptions & Promotions		Bridgemark Healthcare, L.L.C.	100.00%	908	908	18
19	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, L.L.C.	100.00%	132,084	132,084	19
20	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, L.L.C.	100.00%	25,661	25,661	20
21	V	24	Travel & Seminar		Bridgemark Healthcare, L.L.C.	100.00%	1,253	1,253	21
22	V	25	Admin Staff Transportation		Bridgemark Healthcare, L.L.C.	100.00%	10,067	10,067	22
23	V	26	Insurance		Bridgemark Healthcare, L.L.C.	100.00%	1,625	1,625	23
24	V	30	Depreciation		Bridgemark Healthcare, L.L.C.	100.00%	2,470	2,470	24
25	V	32	Interest		Bridgemark Healthcare, L.L.C.	100.00%	21	21	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, L.L.C.	100.00%	21	21	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, L.L.C.	100.00%	7,498	7,498	27
28	V	35	Equipment Rental		Bridgemark Healthcare, L.L.C.	100.00%	270	270	28
29	V								29
30	V								30
31	V								31
32	V	20	Dues, Subscriptions & Promotions		BM Properties I - Benton		526	526	32
33	V	30	Depreciation		BM Properties I - Benton		8,241	8,241	33
34	V	34	Rent - Facility & Grounds	307,950	BM Properties I - Benton		5,000	(302,950)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 561,707			$ 243,016	$ * (318,691)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	273,444	4	8.85	Distribution	$ 26,556	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	$ 26,556		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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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, L.L.C.
Street Address: 11970 Borman Drive, Suite 100
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 431-0511
Fax Number: (314) 754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing & Medical Records	Resident Days	316,121	13	$ 176,191	$ 176,191	27,983	$ 15,596	1
2	17	Owners Compensation	Resident Days	316,121	13	300,000		27,983	26,556	2
3	19	Professional Fees	Resident Days	316,121	13	58,959		27,983	5,219	3
4	20	Dues, Subscriptions	Resident Days	316,121	13	10,259		27,983	908	4
5	21	Salaries - Other	Resident Days	316,121	13	1,022,795	1,022,795	27,983	90,538	5
6	21	Clerical	Resident Days	316,121	13	469,344		27,983	41,546	6
7	22	Employee Benefits	Resident Days	316,121	13	289,889		27,983	25,661	7
8	24	Seminars	Resident Days	316,121	13	14,156		27,983	1,253	8
9	25	Admin Staff Travel	Resident Days	316,121	13	113,730		27,983	10,067	9
10	26	Insurance	Resident Days	316,121	13	18,353		27,983	1,625	10
11	30	Depreciation	Resident Days	316,121	13	27,905		27,983	2,470	11
12	32	Interest	Resident Days	316,121	13	242		27,983	21	12
13	33	Real Estate Taxes	Resident Days	316,121	13	241		27,983	21	13
14	34	Building Rent	Resident Days	316,121	13	83,985		27,983	7,434	14
15	34	Rent	Resident Days	316,121	13	723		27,983	64	15
16	35	Equipment Rent	Resident Days	316,121	13	3,055		27,983	270	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,589,827	$ 1,198,986		$ 229,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry	Revenue	86,808	4	$ 105,701	$ 74,633	25,087	$ 30,547	1
2	5	Utilities	Revenue	86,808	4	28,113		25,087	8,124	2
3	6	Maintenance	Revenue	86,808	4	41,425	35,725	25,087	11,972	3
4	19	Professional Services	Revenue	86,808	4	3,078		25,087	890	4
5	20	Dues, Fees, & Subscriptions	Revenue	86,808	4	32		25,087	9	5
6	21	Clerical & Office Supplies	Revenue	86,808	4	61,572	54,600	25,087	17,794	6
7	22	Payroll Taxes & Emp. Ben.	Revenue	86,808	4	66,706		25,087	19,278	7
8	25	Other Admin Transportation	Revenue	86,808	4	36,969		25,087	10,684	8
9	26	Insurance	Revenue	86,808	4	634		25,087	183	9
10	30	Depreciation	Revenue	86,808	4	15,872		25,087	4,587	10
11	32	Interest	Revenue	86,808	4	78,241		25,087	22,611	11
12	33	Real Estate Taxes	Revenue	86,808	4	12,000		25,087	3,468	12
13	34	Rent	Revenue	86,808	4	4,400		25,087	1,272	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					$ 454,743	$ 164,958		$ 131,419	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Bridgemark Healthcare Allocation										21	7
8	Helia Healthcare Allocation										22,611	8
9	TOTAL Facility Related						$	$			$ 22,632	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,350)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,350)	14
15	TOTALS (line 9+line14)						$	$			$ 21,282	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 33,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (33,000)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 57,000	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.		$ 24,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		8
	2006		9
	2007		10
	2008	See note on	11
	2009	Tax Statement	12

				FOR BHF USE ONLY	
24,000	Line 7, Estimate of property taxes once the county separates the parcel to Bridgemark	13	FROM R. E. TAX STATEMENT FOR 2009	$	13
3,468	Helia Healthcare Allocation	14	PLUS APPEAL COST FROM LINE 5	$	14
21	Bridgemark Healthcare Allocation	15	LESS REFUND FROM LINE 6	$	15
27,489	Total Schedule V, Line 33	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	The parcel for this property has not been split out by the County to		$	$
2.	date. When the facility was owned by the Hospital, it was not assessed		$	$
3.	for real estate taxes. An estimate for real estate taxes has been accrued		$	$
4.	by the provider.		$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Helia Healthcare Allocation			$ 5,652	1
2					2
3	TOTALS			$ 5,652	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Helia Healthcare Allocation		2006		$ 46,500	$	25	$ 1,808	$ 1,808	$ 6,215	4
5	83		2008		134,098		30	4,470	4,470	10,802	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	81	15	81		156	9
10	Exterior Sign			2009	5,265	527	10	527		965	10
11	Landscaping			2009	4,135	414	10	414		724	11
12	Wallcovering for hallways & entranceway, doors, shower remodel			2009	11,252	750	15	750		1,000	12
13	Carpet			2009	1,170	234	5	234		312	13
14	Nurse's Station Remodel/Wiring			2009	2,556	170	15	170		213	14
15											15
16	New Pipes, Install eye wash			2010	2,215	52	25	52		52	16
17	AC, fans, dehumidifier			2010	1,609	80	10	80		80	17
18	Outside single door and frame			2010	4,168	69	15	69		69	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

*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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation - Helia Healthcare		$	$		$	$	$	37
38	Water & Sewer Pipe Installation	2006	549		20	27	27	121	38
39	Plumbing & Heating Installation	2006	657		20	33	33	145	39
40	A/C Unit - 4 Ton	2007	1,584		10	158	158	581	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 216,979	$ 2,377		$ 8,873	$ 6,496	$ 21,435	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 100,041	$ 5,796	$ 13,343	$ 7,547	3-5	$ 47,285	71
72	Current Year Purchases	15,053	563	938	375	5	937	72
73	Fully Depreciated Assets	25,526					25,526	73
74								74
75	TOTALS	$ 140,620	$ 6,359	$ 14,281	$ 7,922		$ 73,748	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	Bridgemark Healthcare Allocation		2005	$ 2,542	$	$ 454	$ 454	5	$ 1,431	76
77	Helia Healthcare Allocation		2006	1,940		426	426	5	916	77
78										78
79										79
80	TOTALS			$ 4,482	$	$ 880	$ 880		$ 2,347	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)	$ 367,733	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,736	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,034	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,298	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 97,530	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.

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 69,401 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$		$ 217,687	$		$ 217,687	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			76,287			76,287	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			258,396	260		258,656	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				214,781		214,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39, 3				81,343			81,343	12
13	Other (specify): Wound Care, Oxy, Ent	39, 2					61,007		61,007	13
14	TOTAL			$		$ 633,713	$ 276,048		$ 909,761	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 500	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 63,134)	474,312		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,267		7
8	Accounts Receivable (owners or related parties)	1,877,647		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,353,726	$	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	33,591		15
16	Equipment, at Historical Cost	80,731		16
17	Accumulated Depreciation (book methods)	(55,222)		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)**	$ 59,100	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,412,826	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 566,861	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,912		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,876		31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 724,649	$	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	123,729		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 123,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 848,378	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,564,448	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,412,826	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,043,556	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,043,556	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	520,892	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)**	$ 520,892	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)**	$ 1,564,448	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,951,508	1
2	Discounts and Allowances for all Levels	(7,561)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,943,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	123,171	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 123,171	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,350	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,350	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recovery of Bad Debt	1,242	28
28a	Miscellaneous Income	328	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,570	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,070,038	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	837,909	31
32	Health Care	1,971,821	32
33	General Administration	924,525	33
	B. Capital Expense		
34	Ownership	412,317	34
	C. Ancillary Expense		
35	Special Cost Centers	357,131	35
36	Provider Participation Fee	45,443	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,549,146	40
41	**Income before Income Taxes (line 30 minus line 40)****	520,892	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 520,892	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 Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 82,344	$ 39.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,002	9,506	205,169	21.58	3
4	Licensed Practical Nurses	19,555	20,127	332,514	16.52	4
5	CNAs & Orderlies	59,602	61,145	584,393	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	199	199	1,709	8.59	8
9	Activity Director					9
10	Activity Assistants	2,676	2,771	32,482	11.72	10
11	Social Service Workers	2,000	2,040	27,844	13.65	11
12	Dietician					12
13	Food Service Supervisor	2,004	2,064	39,207	19.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,829	7,196	65,345	9.08	15
16	Dishwashers					16
17	Maintenance Workers	2,126	2,206	25,819	11.70	17
18	Housekeepers	12,709	13,067	108,164	8.28	18
19	Laundry					19
20	Administrator	2,137	2,153	75,028	34.85	20
21	Assistant Administrator					21
22	Other Administrative	2,603	2,697	28,708	10.64	22
23	Office Manager	2,008	2,080	32,541	15.64	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	2,032	2,080	30,804	14.81	31
32	Other Health C: Unit Aides	479	479	7,216	15.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,001	131,890	$ 1,679,287 *	$ 12.73	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		12,000	9, 3	36
37	Medical Records Consultant		2,840	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,556	10, 3	39
40	Physical Therapy Consultant		2,329	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,813	11, 3	44
45	Social Service Consultant		1,748	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,286		49

C. CONTRACT NURSES

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra McCoy	Administrator	0	$ 75,028
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,028

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 253,757
TOTAL (agree to Schedule V, line 17, col. 3)	$ 253,757
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 5,494
Ceridian	Payroll Processing	8,015
Kramer & Frank	Collection Fees (Unallowable)	200
Much Shelist	Legal Fees	1,291
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,000

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,086
Unemployment Compensation Insurance	41,918
FICA Taxes	128,465
Employee Health Insurance	37,608
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,791
Related Party Allocation - Bridgemark	25,661
Related Party Allocation - Helia	19,278
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,807

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	$ 995
Advertising: Employee Recruitment	3,493
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	2,528
Dues & Subscriptions	3,446
Late Fees	93
Misc Taxes & Licenses	602
Advertising	33,209
Related Party Allocations	1,443
Less: Public Relations Expense	( )
Non-allowable advertising	(33,209)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,600

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Related Party Allocation - Bridgemark	1,253
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,253

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/10 Ending: 12/31/10

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													
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14													
15													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton **#** 0049775 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,092**

(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. $ **8,791** 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. $ **45,443**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) 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.

Helia Healthcare of Benton
Attachment to Schedule VII A
Related Nursing Homes
12/31/2010

Helia Healthcare of Belleville
Helia Healthcare of Carbondale
Helia Healthcare of Champaign
Helia Healthcare of Energy
Helia Healthcare of Olney
Helia Healthcare of Greenville
Frankfort Healthcare & Rehab Center
Helia Southbelt Healthcare
Helia Healthcare of Zion
Hillside Rehab & Care Center
Helia Healthcare of Rolla

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2010

	Description		
16A	Nursing Equipment Rental	$	66,397
16B	Copier Lease		2,734
16C	Related Party Allocation - Bridgemark		270
		$	69,401

Helia Healthcare of Benton
Attachment to Schedule XIX F
Dues, Fees, Subscriptions and Promotions - Related Party Allocations
12/31/2010

	Description		
A	Related Party Allocation - Bridgemark Healthcare	$	908
B	Related Party Allocation - Helia Healthcare		9
C	Related Party Allocation - BM Properties		526
		$	1,443