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: 0046920

Facility Name: Helia Healthcare of Carbondale

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

County: Jackson

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

HFS ID Number:

Date of Initial License for Current Owners: 11/01/04

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 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 Accountants' 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 Carbondale # 0046920 Report Period Beginning: 01/01/10 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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,953	3,953	4,742	20,648	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,953	3,953	4,742	20,648	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.94%

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 [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 4,656

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 Carbondale # 0046920 Report Period Beginning: 01/01/10 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	117,373	18,795	6,624	142,792		142,792		142,792			1
2	Food Purchase		108,757		108,757		108,757	(103)	108,654			2
3	Housekeeping	85,698	22,105		107,803		107,803		107,803			3
4	Laundry	21,605	15,503	48,600	85,708		85,708	7,320	93,028			4
5	Heat and Other Utilities			130,817	130,817		130,817	(614)	130,203			5
6	Maintenance	41,682	22,606	56,500	120,788		120,788	6,471	127,259			6
7	Other (specify):*											7
8	**TOTAL General Services**	266,358	187,766	242,541	696,665		696,665	13,074	709,739			8
	B. Health Care and Programs											
9	Medical Director			10,200	10,200		10,200		10,200			9
10	Nursing and Medical Records	994,136	54,640	3,842	1,052,618		1,052,618	11,434	1,064,052			10
10a	Therapy			454,507	454,507		454,507		454,507			10a
11	Activities	34,329	7,658	4,538	46,525		46,525	(3,123)	43,402			11
12	Social Services	27,783	1,167	7,515	36,465		36,465		36,465			12
13	CNA Training											13
14	Program Transportation			1,088	1,088		1,088		1,088			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,056,248	63,465	481,690	1,601,403		1,601,403	8,311	1,609,714			16
	C. General Administration											
17	Administrative	65,139		190,733	255,872		255,872	(171,138)	84,734			17
18	Directors Fees											18
19	Professional Services			15,494	15,494		15,494	4,555	20,049			19
20	Dues, Fees, Subscriptions & Promotions			36,580	36,580		36,580	(20,602)	15,978			20
21	Clerical & General Office Expenses	41,921	12,207	68,937	123,065		123,065	101,564	224,629			21
22	Employee Benefits & Payroll Taxes			239,382	239,382		239,382	34,186	273,568			22
23	Inservice Training & Education											23
24	Travel and Seminar			978	978		978	925	1,903			24
25	Other Admin. Staff Transportation			9,878	9,878		9,878	15,880	25,758			25
26	Insurance-Prop.Liab.Malpractice			76,009	76,009		76,009	1,344	77,353			26
27	Other (specify):*											27
28	**TOTAL General Administration**	107,060	12,207	637,991	757,258		757,258	(33,286)	723,972			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,429,666	263,438	1,362,222	3,055,326		3,055,326	(11,901)	3,043,425			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 Carbondale #0046920 Report Period Beginning: 01/01/10 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			29,779	29,779		29,779	5,452	35,231			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,216	29,216		29,216	14,297	43,513			32
33	Real Estate Taxes			66,881	66,881		66,881	2,760	69,641			33
34	Rent-Facility & Grounds			321,750	321,750		321,750	6,539	328,289			34
35	Rent-Equipment & Vehicles			57,101	57,101		57,101	200	57,301			35
36	Other (specify):*											36
37	**TOTAL Ownership**			504,727	504,727		504,727	29,248	533,975			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		225,304	39,527	264,831		264,831		264,831			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		225,304	104,132	329,436		329,436		329,436			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,429,666	488,742	1,971,081	3,889,489		3,889,489	17,347	3,906,836			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: 01/01/10 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,123)	11		4
5	Telephone, TV & Radio in Resident Rooms	(7,042)	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	(3,607)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(103)	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	(440)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,863)	21		19
20	Contributions	(1,404)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,040)	21		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,297)	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	(11,284)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,203)		$	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)	62,550	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 62,550		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 17,347		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 Carbondale

ID# 0046920

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	TO ELIMINATE GIFTS AND FLOWERS	$ (5,858)	20	1
2	TO OFFSET MEDICAL RECORDS INCOME	(74)	10	2
3	TO ELIMINATE PAC DUES & LOBBYING EXPENSE	(2,684)	20	3
4	TO OFFSET REIMBURSEMENT FOR PAYROLL	(2,668)	21	4
5	RELATED TO OFFICE WORK DONE BY			5
6	STUDENTS IN A "FUTURES PROGRAM"			6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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19				19
20				20
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26				26
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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**	(11,284)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 **Report Period Beginning:** 01/01/10 **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	(103)	0	0	0	0	0	0	0	0	0	0	(103)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	7,320	0	0	0	0	0	0	0	0	0	7,320	4
5	Heat and Other Utilities	(7,042)	6,428	0	0	0	0	0	0	0	0	0	(614)	5
6	Maintenance	0	6,471	0	0	0	0	0	0	0	0	0	6,471	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,145)	20,219	0	0	0	0	0	0	0	0	0	13,074	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	(74)	0	11,508	0	0	0	0	0	0	0	0	11,434	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,123)	0	0	0	0	0	0	0	0	0	0	(3,123)	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**	(3,197)	0	11,508	0	0	0	0	0	0	0	0	8,311	16
	C. General Administration													
17	Administrative	0	0	(171,138)	0	0	0	0	0	0	0	0	(171,138)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	704	3,851	0	0	0	0	0	0	0	0	4,555	19
20	Fees, Subscriptions & Promotions	(21,279)	7	670	0	0	0	0	0	0	0	0	(20,602)	20
21	Clerical & General Office Expenses	(9,975)	14,077	97,462	0	0	0	0	0	0	0	0	101,564	21
22	Employee Benefits & Payroll Taxes	0	15,251	18,935	0	0	0	0	0	0	0	0	34,186	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	925	0	0	0	0	0	0	0	0	925	24
25	Other Admin. Staff Transportation	0	8,452	7,428	0	0	0	0	0	0	0	0	15,880	25
26	Insurance-Prop.Liab.Malpractice	0	145	1,199	0	0	0	0	0	0	0	0	1,344	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,254)	38,636	(40,668)	0	0	0	0	0	0	0	0	(33,286)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,596)	58,855	(29,160)	0	0	0	0	0	0	0	0	(11,901)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	3,629	1,823	0	0	0	0	0	0	0	0	5,452	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,607)	17,888	16	0	0	0	0	0	0	0	0	14,297	32
33	Real Estate Taxes	0	2,744	16	0	0	0	0	0	0	0	0	2,760	33
34	Rent-Facility & Grounds	0	1,006	5,533	0	0	0	0	0	0	0	0	6,539	34
35	Rent-Equipment & Vehicles	0	0	200	0	0	0	0	0	0	0	0	200	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,607)	25,267	7,588	0	0	0	0	0	0	0	0	29,248	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)	(45,203)	84,122	(21,572)	0	0	0	0	0	0	0	0	17,347	45

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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 Services	St. Louis	Management Co.
				Helia Healthcare Services	Benton	Laundry, Maint.
				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	$ 16,847	Helia Healthcare Services	100.00%	$ 24,167	$ 7,320	1
2	V	5	Utilities		Helia Healthcare Services	100.00%	6,428	6,428	2
3	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	9,471	6,471	3
4	V	19	Professional Services		Helia Healthcare Services	100.00%	704	704	4
5	V	20	Dues, Subscriptions, & Fees		Helia Healthcare Services	100.00%	7	7	5
6	V	21	Clerical		Helia Healthcare Services	100.00%	14,077	14,077	6
7	V	22	Employee Benefits		Helia Healthcare Services	100.00%	15,251	15,251	7
8	V	25	Admin Staff Travel		Helia Healthcare Services	100.00%	8,452	8,452	8
9	V	26	Insurance		Helia Healthcare Services	100.00%	145	145	9
10	V	30	Depreciation		Helia Healthcare Services	100.00%	3,629	3,629	10
11	V	32	Interest		Helia Healthcare Services	100.00%	17,888	17,888	11
12	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	2,744	2,744	12
13	V	34	Rent		Helia Healthcare Services	100.00%	1,006	1,006	13
14	Total			$ 19,847			$ 103,969	$ * 84,122	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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%	$ 11,508	$ 11,508	15
16	V	17	Management Fees	190,733	Bridgemark Healthcare, L.L.C.	100.00%	19,595	(171,138)	16
17	V	19	Professional Fees		Bridgemark Healthcare, L.L.C.	100.00%	3,851	3,851	17
18	V	20	Dues, Subscriptions		Bridgemark Healthcare, L.L.C.	100.00%	670	670	18
19	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, L.L.C.	100.00%	97,462	97,462	19
20	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, L.L.C.	100.00%	18,935	18,935	20
21	V	24	Travel & Seminars		Bridgemark Healthcare, L.L.C.	100.00%	925	925	21
22	V	25	Admin Staff Transportation		Bridgemark Healthcare, L.L.C.	100.00%	7,428	7,428	22
23	V	26	Insurance		Bridgemark Healthcare, L.L.C.	100.00%	1,199	1,199	23
24	V	30	Depreciation		Bridgemark Healthcare, L.L.C.	100.00%	1,823	1,823	24
25	V	32	Interest		Bridgemark Healthcare, L.L.C.	100.00%	16	16	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, L.L.C.	100.00%	16	16	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, L.L.C.	100.00%	5,533	5,533	27
28	V	35	Equipment Rental		Bridgemark Healthcare, L.L.C.	100.00%	200	200	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			$ 190,733			$ 169,161	$ * (21,572)	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 Carbondale # 0046920 Report Period Beginning: 01/01/10 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	280,405	3	6.53	Distribution	$ 19,595	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	$ 19,595		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 Carbondale # 0046920 Report Period Beginning: 01/01/10 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	20,648	$ 11,508	1
2	17	Owners Compensation	Resident Days	316,121	13	300,000		20,648	19,595	2
3	19	Professional Fees	Resident Days	316,121	13	58,959		20,648	3,851	3
4	20	Dues, Subscriptions	Resident Days	316,121	13	10,259		20,648	670	4
5	21	Salaries - Other	Resident Days	316,121	13	1,022,795	1,022,795	20,648	66,806	5
6	21	Clerical	Resident Days	316,121	13	469,344		20,648	30,656	6
7	22	Employee Benefits	Resident Days	316,121	13	289,889		20,648	18,935	7
8	24	Seminars	Resident Days	316,121	13	14,156		20,648	925	8
9	25	Admin Staff Travel	Resident Days	316,121	13	113,730		20,648	7,428	9
10	26	Insurance	Resident Days	316,121	13	18,353		20,648	1,199	10
11	30	Depreciation	Resident Days	316,121	13	27,905		20,648	1,823	11
12	32	Interest	Resident Days	316,121	13	242		20,648	16	12
13	33	Real Estate Taxes	Resident Days	316,121	13	241		20,648	16	13
14	34	Building Rent	Resident Days	316,121	13	83,985		20,648	5,486	14
15	34	Rental - Storage Unit	Resident Days	316,121	13	723		20,648	47	15
16	35	Equipment Rental	Resident Days	316,121	13	3,055		20,648	200	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		$ 169,161	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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	19,847	$ 24,167	1
2	5	Utilities	Revenue	86,808	4	28,113		19,847	6,428	2
3	6	Maintenance	Revenue	86,808	4	41,425	35,725	19,847	9,471	3
4	19	Professional services	Revenue	86,808	4	3,078		19,847	704	4
5	20	Dues, Fees, & Subscriptions	Revenue	86,808	4	32		19,847	7	5
6	21	Clerical & Office Supplies	Revenue	86,808	4	61,572	54,600	19,847	14,077	6
7	22	Payroll Taxes & Emp. Ben.	Revenue	86,808	4	66,706		19,847	15,251	7
8	25	Other Admin Transportation	Revenue	86,808	4	36,969		19,847	8,452	8
9	26	Insurance	Revenue	86,808	4	634		19,847	145	9
10	30	Depreciation	Revenue	86,808	4	15,872		19,847	3,629	10
11	32	Interest	Revenue	86,808	4	78,241		19,847	17,888	11
12	33	Real Estate Taxes	Revenue	86,808	4	12,000		19,847	2,744	12
13	34	Rent	Revenue	86,808	4	4,400		19,847	1,006	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		$ 103,969	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	29,216	6
7	Related Party Alloc. - Helia Healthcare										17,888	7
8	Related Party Alloc. - Bridgemark Healthcare										16	8
9	TOTAL Facility Related						$	$			$ 47,120	9
	B. Non-Facility Related*											
10	Interest Income										(3,607)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,607)	14
15	TOTALS (line 9+line14)						$	$			$ 43,513	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 Carbondale # 0046920 **Report Period Beginning:** 01/01/10 **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.**	$	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.)		$ 66,881	2
3. Under or (over) accrual (line 2 minus line 1).		$ 66,881	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 66,881	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	56,665	8
2006	59,043	9
2007	58,933	10
2008	60,911	11
2009	61,442	12

66,881	Line 7, Real Estate Tax portion of Lease Payments
2,744	Helia Healthcare Allocation
16	Bridgemark Healthcare Allocation
69,641	Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Carbondale COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0046920

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

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

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

Enter the tax index number and real estate tax assessed for 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.	15-22-326-010	Long Term Care	$ 61,441.68	$ 61,441.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,441.68	$ 61,441.68

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 Carbondale # 0046920 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 1

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation - Helia Healthcare			$ 4,471	1
2					2
3	TOTALS			$ 4,471	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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	Related Party Allocation- Helia Healthcare		2006	2006	$ 36,787	$	25	$ 1,431	$ 1,431	$ 4,916	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Concrete			2005	1,575	158	10	158		841	9
10	Fire Sprinkler			2005	2,070	310	5	310		2,070	10
11	Nurses Station & Med Room			2005	20,510	2,051	10	2,051		10,426	11
12	Exterior Sign			2005	319	26	5	26		319	12
13	Cubicle Curtains			2005	1,432		3			1,432	13
14	Door Signs			2005	512		3			512	14
15	Weatherproof Lights			2006	4,719	472	10	472		2,360	15
16	Phone Lines			2006	1,001	201	5	201		1,001	16
17	3-4 Ton A/C Units			2006	7,500	1,500	5	1,500		6,750	17
18	New Nurses Station			2006	2,995	300	10	300		1,348	18
19	New Sprinkler System			2007	39,969	3,997	10	3,997		14,944	19
20	Roof Repair			2007	13,608	1,361	10	1,361		4,649	20
21	Compressor			2007	1,672	167	10	167		557	21
22	Front Building Sign			2007	1,271	127	10	127		456	22
23	Lowes- Tile			2008	738	74	10	74		203	23
24	Installed Sims 232 Card			2008	1,106	111	10	111		295	24
25	Roof Replacement			2008	14,548	1,455	10	1,455		3,152	25
26	Ceiling Tiles			2008	1,308	131	10	131		273	26
27	Fire Protection Annunciator for Front			2008	1,111	111	10	111		222	27
28	Plumbing Repair			2009	8,223	411	20	411		685	28
29	A/C Compressors			2009	2,489	166	15	166		249	29
30	Water Heater/ Expansion Tank			2009	1,155	115	10	115		116	30
31	Dry Pendent - Sprinkler System			2010	2,945	180	15	180		180	31
32	4-5 ton air handler			2010	3,000	125	20	125		125	32
33	Fire equip - new accelerator & check			2010	2,408	181	10	181		181	33
34	New locks			2010	770	82	7	82		82	34
35	Tear out existing pad and repour concrete			2010	2,500	111	15	111		111	35
36	20 KW Power generator			2010	9,750	812	5	812		812	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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: 01/01/10 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	434		20	22	22	96	38
39	Plumbing & Heating Installation	2006	520		20	26	26	115	39
40	A/C Unit - 4 Ton	2007	1,253		10	125	125	459	40
41									41
42									42
43									43
44									44
45	Biohazard Shed	2010	1,649	96	10	96		96	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)		$ 191,847	$ 14,831		$ 16,435	$ 1,604	$ 60,033	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 Carbondale # 0046920 Report Period Beginning: 01/01/10 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	$ 78,095	$ 11,598	$ 14,497	$ 2,899	3-10	$ 48,439	71
72	Current Year Purchases	3,883	38	315	277	3-10	315	72
73	Fully Depreciated Assets	28,281					28,281	73
74								74
75	TOTALS	$ 110,259	$ 11,636	$ 14,812	$ 3,176		$ 77,035	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	$ 1,999	$ 1,999	$	4	$ 4,997	76
77	Facility	Truck	2008	5,250	1,313	1,313		4	3,172	77
78	Related Party Allocation - Bridgemark			1,876		335	335	5	1,056	78
79	Related Party Allocation - Helia			1,535		337	337	5	725	79
80	TOTALS			$ 16,656	$ 3,312	$ 3,984	$ 672		$ 9,950	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)	$ 323,233	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,779	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,231	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,452	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 147,018	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 Carbondale # 0046920 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118		$ 321,750			3
4	Additions							4
5	Related Party Allocation - Helia				1,006			5
6	Related Party Allocation - Bridgemark				5,533			6
7	TOTAL		118		$ 328,289 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 57,301 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 Carbondale # 0046920 Report Period Beginning: 01/01/10 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 Carbondale

STATE OF ILLINOIS
0046920 Report Period Beginning: 01/01/10 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	$		$ 165,111	$		$ 165,111	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			110,068			110,068	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			179,328			179,328	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				167,852		167,852	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39, 3				39,527			39,527	12
13	Other (specify): Wound Care, Oxy, Ent	39, 2					57,452		57,452	13
14	TOTAL			$		$ 494,034	$ 225,304		$ 719,338	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: 01/01/10 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	$ 2,159	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 96,591)	336,129		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,583		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	500		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 340,371	$	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	137,447		15
16	Equipment, at Historical Cost	121,965		16
17	Accumulated Depreciation (book methods)	(129,644)		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)**	$ 129,768	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 470,139	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 410,241	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,848		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,727		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Bridgemark Healthcare	339,954		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 838,770	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	147,431		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 147,431	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 986,201	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (516,062)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 470,139	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (383,354)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (383,354)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,708)	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)**	$ (132,708)	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)**	$ (516,062)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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	$ 3,620,324	1
2	Discounts and Allowances for all Levels	(71,006)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,549,318	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	166,140	6
7	Oxygen	26,612	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 192,752	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	3,123	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)**	$ 3,123	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,607	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,607	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	7,981	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,981	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,756,781	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	696,665	31
32	Health Care	1,601,403	32
33	General Administration	757,258	33
	B. Capital Expense		
34	Ownership	504,727	34
	C. Ancillary Expense		
35	Special Cost Centers	264,831	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,889,489	40
41	**Income before Income Taxes (line 30 minus line 40)****	(132,708)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (132,708)	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: 01/01/10 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	1,968	1,968	$ 53,303	$ 27.08	1
2	Assistant Director of Nursing	1,411	1,507	21,756	14.44	2
3	Registered Nurses	4,370	4,618	105,238	22.79	3
4	Licensed Practical Nurses	17,545	18,908	326,493	17.27	4
5	CNAs & Orderlies	42,698	45,557	453,903	9.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,001	3,079	34,329	11.15	10
11	Social Service Workers	1,948	1,990	27,783	13.96	11
12	Dietician					12
13	Food Service Supervisor	2,170	2,289	32,347	14.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,734	10,143	85,026	8.38	15
16	Dishwashers					16
17	Maintenance Workers	2,665	2,725	41,682	15.30	17
18	Housekeepers	8,933	9,232	85,698	9.28	18
19	Laundry	2,570	2,570	21,605	8.41	19
20	Administrator	1,979	2,075	65,139	31.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,289	2,440	41,921	17.18	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	1,548	1,607	17,819	11.09	31
32	Other Health Care(specify)					32
33	Other(specify) Restorative Aide	1,181	1,284	15,624	12.17	33
34	TOTAL (lines 1 - 33)	106,010	111,992	$ 1,429,666 *	$ 12.77	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		$ 6,624	1, 3	35
36	Medical Director		10,200	9, 3	36
37	Medical Records Consultant		1,742	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,100	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		4,538	11, 3	44
45	Social Service Consultant		7,515	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,719		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 Carbondale # 0046920 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristi Karch	Administrator	0	$ 39,480
Gina Graham	Administrator	0	25,659
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 65,139

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 190,733
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 190,733

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Co.	Accounting Services	$ 4,150
Ceridian	Payroll Processing	8,703
Craig & Craig	Legal Fees	2,419
Much Shelist	Legal Fees	222
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,494

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,712
Unemployment Compensation Insurance	39,432
FICA Taxes	107,705
Employee Health Insurance	26,031
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	1,502
Related Party Allocation - Bridgemark	18,935
Related Party Allocation - Helia Healthcare	15,251
TOTAL (agree to Schedule V, line 22, col.8)	$ 273,568

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	$
Advertising: Employee Recruitment	5,198
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	3,072
Dues & Subscriptions	5,784
Advertising	12,297
Miscellaneous Licenses & Fees	1,247
Related Party Allocation - Bridgemark	670
Related Party Allocation - Helia	7
Less: Public Relations Expense	( )
Non-allowable advertising	(12,297)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,978

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	530
Seminar Expense	448
Related Party Allocation - Bridgemark	925
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,903

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale # 0046920 Report Period Beginning: 01/01/10 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													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Carbondale **#** 0046920 **Report Period Beginning:** 01/01/10 **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 $4,396**

(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. $ **9,103** 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. $ **64,605**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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 Carbondale
Attachment to Schedule VII A
Related Nursing Homes
40543

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

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

	Description		
16A	Nursing Equipment Rental	$	50,692
16B	Copier Lease		5,461
16C	Dietary Equipment Rental		948
16D	Related Party Allocation - Bridgemark		200
		$	57,301

Helia Healthcare of Carbondale
Attachment to Schedule XVII
Other Revenue
12/31/2010

Description		
Recovery of Bad Debt	$	4,500
Medical Record Copies	$	74
Payroll Reimbursement	$	2,668
Miscellaneous		739
	$	7,981