

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0046680</u></p> <p><b>Facility Name:</b> <u>Helia Healthcare of Greenville</u></p> <p><b>Address:</b> <u>400 East Hillview Avenue</u> <u>Greenville</u> <u>62246</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Bond</u></p> <p><b>Telephone Number:</b> <u>(618) 664-1622</u> <b>Fax #</b> <u>(618) 664-1283</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/04</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Cindy A. Tefteller</u> <b>Telephone Number:</b> <u>(618) 465-7717</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/10</u> to <u>12/31/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name &amp; Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> <b>Fax #</b> <u>(618) 465-7710</u></td> </tr> </table> <p><b>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</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u>	<b>Paid Preparer</b>	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> <b>Fax #</b> <u>(618) 465-7710</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Greenville

# 0046680 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	9,642	3,378	2,498	15,518	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,642	3,378	2,498	15,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.24%

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

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

I. On what date did you start providing long term care at this location?  
Date started 12/31/03

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/31/03 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 34 and days of care provided 2,175

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Helia Healthcare of Greenville # 0046680 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	97,947	7,297	4,853	110,097		110,097		110,097		1
2	Food Purchase		92,764		92,764		92,764	(100)	92,664		2
3	Housekeeping	73,147	14,727		87,874		87,874		87,874		3
4	Laundry	10,659	2,028		12,687		12,687		12,687		4
5	Heat and Other Utilities			80,465	80,465		80,465	(7,945)	72,520		5
6	Maintenance	23,680	3,649	31,626	58,955		58,955		58,955		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	205,433	120,465	116,944	442,842		442,842	(8,045)	434,797		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	745,951	39,120	3,427	788,498		788,498	8,649	797,147		10
10a	Therapy			207,099	207,099		207,099		207,099		10a
11	Activities	35,065	3,546	3,843	42,454		42,454		42,454		11
12	Social Services	35,012	40	2,584	37,636		37,636		37,636		12
13	CNA Training										13
14	Program Transportation			6,987	6,987		6,987		6,987		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	816,028	42,706	233,540	1,092,274		1,092,274	8,649	1,100,923		16
	<b>C. General Administration</b>										
17	Administrative	83,314		118,822	202,136		202,136	(104,095)	98,041		17
18	Directors Fees										18
19	Professional Services			27,718	27,718	2,671	30,389	2,894	33,283		19
20	Dues, Fees, Subscriptions & Promotions			36,952	36,952		36,952	(26,929)	10,023		20
21	Clerical & General Office Expenses	25,469	8,771	51,167	85,407	(2,671)	82,736	68,060	150,796		21
22	Employee Benefits & Payroll Taxes			196,716	196,716		196,716	14,230	210,946		22
23	Inservice Training & Education										23
24	Travel and Seminar			462	462		462	695	1,157		24
25	Other Admin. Staff Transportation			5,142	5,142		5,142	5,583	10,725		25
26	Insurance-Prop.Liab.Malpractice			55,936	55,936		55,936	901	56,837		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	108,783	8,771	492,915	610,469		610,469	(38,661)	571,808		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,130,244	171,942	843,399	2,145,585		2,145,585	(38,057)	2,107,528		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			19,667	19,667		19,667	1,631	21,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,718	71,718		71,718	(278)	71,440			32
33	Real Estate Taxes			24,000	24,000		24,000	12	24,012			33
34	Rent-Facility & Grounds			198,000	198,000		198,000	4,158	202,158			34
35	Rent-Equipment & Vehicles			10,816	10,816		10,816	150	10,966			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			324,201	324,201		324,201	5,673	329,874			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		111,547	25,158	136,705		136,705		136,705			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		111,547	74,433	185,980		185,980		185,980			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,130,244	283,489	1,242,033	2,655,766		2,655,766	(32,384)	2,623,382			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 Greenville**

# **0046680**

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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(7,945)	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	261	30		9
10	Interest and Other Investment Income	(290)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(100)	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	(120)	20		17
18	Fines and Penalties	(5,000)	21		18
19	Entertainment	(188)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,708)	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	(3,605)	20		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (40,695)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	8,311	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 8,311		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (32,384)		37

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

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

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

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Greenville

ID# 0046680

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	TO ELIMINATE GIFTS AND FLOWERS	\$ (1,557)	20	1
2	TO ELIMINATE LOBBYING & PAC DUES	(2,048)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,605)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Greenville# 0046680

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(100)	0	0	0	0	0	0	0	0	0	0	(100)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,945)	0	0	0	0	0	0	0	0	0	0	(7,945)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,045)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,045)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	8,649	0	0	0	0	0	0	0	0	0	8,649	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>8,649</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,649</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(104,095)	0	0	0	0	0	0	0	0	0	(104,095)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,894	0	0	0	0	0	0	0	0	0	2,894	19
20	Fees, Subscriptions & Promotions	(27,433)	504	0	0	0	0	0	0	0	0	0	(26,929)	20
21	Clerical & General Office Expenses	(5,188)	73,248	0	0	0	0	0	0	0	0	0	68,060	21
22	Employee Benefits & Payroll Taxes	0	14,230	0	0	0	0	0	0	0	0	0	14,230	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	695	0	0	0	0	0	0	0	0	0	695	24
25	Other Admin. Staff Transportation	0	5,583	0	0	0	0	0	0	0	0	0	5,583	25
26	Insurance-Prop.Liab.Malpractice	0	901	0	0	0	0	0	0	0	0	0	901	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(32,621)</b>	<b>(6,040)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(38,661)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(40,666)</b>	<b>2,609</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(38,057)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Greenville# 0046680

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	261	1,370	0	0	0	0	0	0	0	0	0	1,631	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(290)	12	0	0	0	0	0	0	0	0	0	(278)	32
33	Real Estate Taxes	0	12	0	0	0	0	0	0	0	0	0	12	33
34	Rent-Facility & Grounds	0	4,158	0	0	0	0	0	0	0	0	0	4,158	34
35	Rent-Equipment & Vehicles	0	0	150	0	0	0	0	0	0	0	0	150	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(29)</b>	<b>5,552</b>	<b>150</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,673</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(40,695)	8,161	150	0	0	0	0	0	0	0	0	(32,384)	45

**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 Healthcare Services	Benton	Laundry, Maint
				Bridgemark Employer Service	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.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing & Medical Records	\$	Bridgemark Healthcare, L.L.C.	100.00%	\$ 8,649	\$ 8,649	1
2	V	17 Administrative	118,822	Bridgemark Healthcare, L.L.C.	100.00%	14,727	(104,095)	2
3	V	19 Professional Services		Bridgemark Healthcare, L.L.C.	100.00%	2,894	2,894	3
4	V	20 Dues, Subscriptions		Bridgemark Healthcare, L.L.C.	100.00%	504	504	4
5	V	21 Clerical & General Office		Bridgemark Healthcare, L.L.C.	100.00%	73,248	73,248	5
6	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, L.L.C.	100.00%	14,230	14,230	6
7	V	24 Travel & Seminars		Bridgemark Healthcare, L.L.C.	100.00%	695	695	7
8	V	25 Admin Staff Transportation		Bridgemark Healthcare, L.L.C.	100.00%	5,583	5,583	8
9	V	26 Insurance		Bridgemark Healthcare, L.L.C.	100.00%	901	901	9
10	V	30 Depreciation		Bridgemark Healthcare, L.L.C.	100.00%	1,370	1,370	10
11	V	32 Interest		Bridgemark Healthcare, L.L.C.	100.00%	12	12	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, L.L.C.	100.00%	12	12	12
13	V	34 Rent - Facility & Grounds		Bridgemark Healthcare, L.L.C.	100.00%	4,158	4,158	13
14	Total		\$ 118,822			\$ 126,983	\$ * 8,161	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Equipment Rental	\$	Bridgemark Healthcare, L.L.C.	100.00%	\$ 150	\$	150	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 150	\$ *	150	39

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

Facility Name & ID Number Helia Healthcare of Greenville # 0046680 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	285,273	2	4.91	Distribution	\$ 14,727	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	\$ 14,727		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Greenville

# 0046680

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing & Medical Records	Resident Days	316,121	13	\$ 176,191	\$ 176,191	15,518	\$ 8,649	1
2	17	Owners Compensation	Resident Days	316,121	13	300,000		15,518	14,727	2
3	19	Professional Fees	Resident Days	316,121	13	58,959		15,518	2,894	3
4	20	Dues, Subscriptions	Resident Days	316,121	13	10,259		15,518	504	4
5	21	Salaries - Other	Resident Days	316,121	13	1,022,795	1,022,795	15,518	50,208	5
6	21	Clerical	Resident Days	316,121	13	469,344		15,518	23,040	6
7	22	Employee Benefits	Resident Days	316,121	13	289,889		15,518	14,230	7
8	24	Seminars	Resident Days	316,121	13	14,156		15,518	695	8
9	25	Admin Staff Travel	Resident Days	316,121	13	113,730		15,518	5,583	9
10	26	Insurance	Resident Days	316,121	13	18,353		15,518	901	10
11	30	Depreciation	Resident Days	316,121	13	27,905		15,518	1,370	11
12	32	Interest	Resident Days	316,121	13	242		15,518	12	12
13	33	Real Estate Taxes	Resident Days	316,121	13	241		15,518	12	13
14	34	Building Rent	Resident Days	316,121	13	83,985		15,518	4,123	14
15	34	Rental - Storage Unit	Resident Days	316,121	13	723		15,518	35	15
16	35	Equipment Rental	Resident Days	316,121	13	3,055		15,518	150	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		\$ 127,133	25

SEE ACCOUNTANTS' COMPILATION REPORT



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2009 report.		\$	<b>2,000</b>		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.)		\$	<b>26,000</b>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>24,000</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>24,000</b>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2005	<u>26,724</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		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
<b>FOR BHF USE ONLY</b>																			
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																	
	2006	<u>27,751</u>	9																
	2007	<u>31,590</u>	10																
	2008	<u>32,741</u>	11																
	2009	<u>34,391</u>	12																
<b>24,000</b> Line 7, Real Estate taxes included in Lease Payments																			
<b>12</b> Bridgemark Healthcare Allocation																			
<b>24,012</b> Total Schedule V, Line 33																			

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**



Facility Name & ID Number Helia Healthcare of Greenville

# 0046680

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Section N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Generator		2004	4,102		5			4,102	9
10	Shed		2004	752		5			752	10
11	Generator		2004	2,100		5			2,100	11
12	Generator Freight		2004	1,134		5			1,134	12
13	Fire System Repair		2004	1,229		10	123	123	861	13
14	Shed		2004	1,383		10	138	138	968	14
15	Sidewalk		2005	2,450	245	10	245		1,388	15
16	Sidewalk		2005	1,096	110	10	110		621	16
17	Hot Water Heater		2006	1,175	117	10	117		528	17
18	Concrete		2006	946	189	5	189		883	18
19	A/C Heat Unit		2006	1,626	325	5	325		1,301	19
20	Kitchen Exhaust System		2007	5,940	594	10	594		1,980	20
21	A/C Heat Unit		2007	1,556	311	5	311		1,063	21
22	Wing Remodel Project		2007	6,811	341	20	341		1,022	22
23	Wing Remodel Project		2008	107,282	5,364	20	5,364		10,728	23
24	New Center B-Wing Call System		2008	5,157	516	10	516		1,289	24
25	Stepsmart Flooring - Carpet		2008	10,301	2,060	5	2,060		4,292	25
26	Call System		2008	2,998	300	10	300		750	26
27	Signs		2008	1,182	118	10	118		236	27
28	Wing Remodeling, doors, flooring, railings, and nurses station		2009	20,539	1,369	15	1,369		2,666	28
29	Heating & A/C		2009	5,995	400	15	400		600	29
30	Cable Installation		2009	3,500	350	10	350		496	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								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)	\$	\$		\$	\$	\$	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 Greenville

# 0046680

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	\$ 52,133	\$ 6,762	\$ 7,672	\$ 910	3-15	\$ 22,545	71
72	Current Year Purchases	2,761	196	404	208	3-15	404	72
73	Fully Depreciated Assets	16,701					16,701	73
74								74
75	TOTALS	\$ 71,595	\$ 6,958	\$ 8,076	\$ 1,118		\$ 39,650	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	Related Party Allocation - Bridgemark			\$ 1,410	\$	\$ 252	\$ 252	5	\$ 794	76
77										77
78										78
79										79
80	TOTALS			\$ 1,410	\$	\$ 252	\$ 252		\$ 794	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)	\$ 262,259	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,667	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,298	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,631	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 80,204	85

\*\*

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: First Healthcare Associates

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:	<u>90</u>		\$ <u>198,000</u>			3
4	Additions						4
5	<u>Related Party Allocation - Bridgemark</u>			<u>4,158</u>			5
6							6
7	<b>TOTAL</b>	<b>90</b>		\$ <b>202,158</b>			<b>7</b>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 10,966 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	<u>Section N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

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 \$ \_\_\_\_\_

\* 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.

**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.)**

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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**

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a, 3	hrs	\$		\$	81,202	\$		\$	81,202	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs				31,253				31,253	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a, 3	hrs				94,644				94,644	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 prescripts					92,267			92,267	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Wound Care, Oxygen</u>	39, 2						19,280			19,280	12
13	Other (specify): <u>Lab, X-Ray</u>	39, 3					25,158				25,158	13
14	TOTAL			\$		\$	232,257	\$	111,547	\$	343,804	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Helia Healthcare of Greenville**

# **0046680**

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,380	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>70,040</u> )	300,414		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):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 303,377	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	179,206		15
16	Equipment, at Historical Cost	72,739		16
17	Accumulated Depreciation (book methods)	(74,784)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 177,161	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 480,538	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 221,847	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,544		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,996		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to Related Party</u>	1,156,207		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,447,594	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Note Payable - Owner</u>	234,983		43
44	<u>Note Payable - Lessor</u>	440,094		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 675,077	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,122,671	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,642,133)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 480,538	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,374,537)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,374,537)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(267,596)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(267,596)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,642,133)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Greenville# 0046680Report Period Beginning: 01/01/10Ending: 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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,276,848	1
2	Discounts and Allowances for all Levels	11,331	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,288,179</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,760	6
7	Oxygen	1,752	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 99,512</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	290	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 290</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	189	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 189</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,388,170</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	442,842	31
32	Health Care	1,092,274	32
33	General Administration	610,469	33
<b>B. Capital Expense</b>			
34	Ownership	324,201	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	136,705	35
36	Provider Participation Fee	49,275	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,655,766</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(267,596)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (267,596)</b>	<b>43</b>

\* 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 Greenville**

# **0046680**

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,802	1,802	\$ 52,177	\$ 28.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,292	4,655	130,455	28.02	3
4	Licensed Practical Nurses	11,304	11,576	231,039	19.96	4
5	CNAs & Orderlies	27,428	28,358	297,968	10.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,463	2,511	35,065	13.96	10
11	Social Service Workers	1,952	1,952	35,012	17.94	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,201	13.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,378	7,831	70,746	9.03	15
16	Dishwashers					16
17	Maintenance Workers	1,867	1,935	23,680	12.24	17
18	Housekeepers	7,515	7,911	73,147	9.25	18
19	Laundry	1,166	1,232	10,659	8.65	19
20	Administrator	1,812	1,812	83,314	45.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,976	2,049	25,469	12.43	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	2,080	2,080	34,312	16.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	75,115	77,784	\$ 1,130,244 *	\$ 14.53	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 4,853	1, 3	35
36	Medical Director	9,600	9, 3	36
37	Medical Records Consultant	496	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,931	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	3,843	11, 3	44
45	Social Service Consultant	2,584	12, 3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,307		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



**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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Greenville# 0046680

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 \$3,352
- (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? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,977 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. \$ 49,275  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ N/A 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

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

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

Description		
16A	Nursing Equipment Rental	\$ 7,097
16B	Dietary Equipment Rental	948
16C	Copier Lease	2,771
16D	Related Party Allocation - Bridgemark	150
		<u>\$ 10,966</u>