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: 0050310

Facility Name: Hillside Rehab & Care Center

Address: 1308 Game Farm Road (Number) Yorkville (City) 60560 (Zip Code)

County: Kendall

Telephone Number: (630) 553-5811 **Fax #** (630) 553-2740

HFS ID Number:

Date of Initial License for Current Owners: 01/15/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	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	13,769	6,397	3,339	23,505	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,769	6,397	3,339	23,505	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.52%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/15/09

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/15/09 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 2,505

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 Hillside Rehab & Care Center # 0050310 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	151,362	9,685	7,745	168,792		168,792		168,792			1
2	Food Purchase		122,834		122,834		122,834	(165)	122,669			2
3	Housekeeping	121,048	13,917		134,965		134,965		134,965			3
4	Laundry	13,558	11,732	22,190	47,480		47,480		47,480			4
5	Heat and Other Utilities			79,203	79,203		79,203	(12,249)	66,954			5
6	Maintenance	20,609	7,223	32,335	60,167		60,167		60,167			6
7	Other (specify):*											7
8	TOTAL General Services	306,577	165,391	141,473	613,441		613,441	(12,414)	601,027			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,239,661	100,897	3,083	1,343,641		1,343,641	13,101	1,356,742			10
10a	Therapy		1,258	341,421	342,679		342,679		342,679			10a
11	Activities	38,069	4,112	1,581	43,762		43,762		43,762			11
12	Social Services	52,122		961	53,083		53,083		53,083			12
13	CNA Training											13
14	Program Transportation			80	80		80		80			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,329,852	106,267	355,526	1,791,645		1,791,645	13,101	1,804,746			16
	C. General Administration											
17	Administrative	90,261		209,553	299,814		299,814	(187,247)	112,567			17
18	Directors Fees											18
19	Professional Services			11,983	11,983		11,983	4,384	16,367			19
20	Dues, Fees, Subscriptions & Promotions			27,357	27,357		27,357	(19,251)	8,106			20
21	Clerical & General Office Expenses	57,868	17,803	50,006	125,677		125,677	108,236	233,913			21
22	Employee Benefits & Payroll Taxes			286,248	286,248		286,248	21,555	307,803			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,139	1,139		1,139	1,053	2,192			24
25	Other Admin. Staff Transportation			4,378	4,378		4,378	8,456	12,834			25
26	Insurance-Prop.Liab.Malpractice			45,953	45,953		45,953	1,365	47,318			26
27	Other (specify):*											27
28	TOTAL General Administration	148,129	17,803	636,617	802,549		802,549	(61,449)	741,100			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,784,558	289,461	1,133,616	3,207,635		3,207,635	(60,762)	3,146,873			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 Hillside Rehab & Care Center #0050310 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			7,323	7,323		7,323	2,075	9,398			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,226	3,226		3,226	(245)	2,981			32
33	Real Estate Taxes			88,150	88,150		88,150	18	88,168			33
34	Rent-Facility & Grounds			356,268	356,268		356,268	6,299	362,567			34
35	Rent-Equipment & Vehicles			39,498	39,498		39,498	227	39,725			35
36	Other (specify):*											36
37	TOTAL Ownership			494,465	494,465		494,465	8,374	502,839			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,066	8,682	103,748		103,748		103,748			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,253	43,253		43,253		43,253			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		95,066	51,935	147,001		147,001		147,001			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,784,558	384,527	1,680,016	3,849,101		3,849,101	(52,388)	3,796,713			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 Hillside Rehab & Care Center # 0050310 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,928)	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	(263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	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	(400)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,461)	21		19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,136)	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	(10,799)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,402)		$	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)	(16,986)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (16,986)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,388)		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

Hillside Rehab & Care Center

ID# 0050310

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	TO ELIMINATE GIFTS AND FLOWERS	$ (4,681)	20	1
2	TO ELIMINATE PAC DUES	(1,797)	20	2
3	TO OFFSET DEPOSIT REFUND	(4,321)	5	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,799)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillside Rehab & Care Center **#** 0050310 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(165)	0	0	0	0	0	0	0	0	0	0	(165)	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	(12,249)	0	0	0	0	0	0	0	0	0	0	(12,249)	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	**TOTAL General Services**	(12,414)	0	0	0	0	0	0	0	0	0	0	(12,414)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	13,101	0	0	0	0	0	0	0	0	0	13,101	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	13,101	0	0	0	0	0	0	0	0	0	13,101	16
	C. General Administration													
17	Administrative	0	(187,247)	0	0	0	0	0	0	0	0	0	(187,247)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,384	0	0	0	0	0	0	0	0	0	4,384	19
20	Fees, Subscriptions & Promotions	(20,014)	763	0	0	0	0	0	0	0	0	0	(19,251)	20
21	Clerical & General Office Expenses	(2,711)	110,947	0	0	0	0	0	0	0	0	0	108,236	21
22	Employee Benefits & Payroll Taxes	0	21,555	0	0	0	0	0	0	0	0	0	21,555	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,053	0	0	0	0	0	0	0	0	0	1,053	24
25	Other Admin. Staff Transportation	0	8,456	0	0	0	0	0	0	0	0	0	8,456	25
26	Insurance-Prop.Liab.Malpractice	0	1,365	0	0	0	0	0	0	0	0	0	1,365	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,725)	(38,724)	0	0	0	0	0	0	0	0	0	(61,449)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,139)	(25,623)	0	0	0	0	0	0	0	0	0	(60,762)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 **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)	
	D. Ownership													
30	Depreciation	0	2,075	0	0	0	0	0	0	0	0	0	2,075	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(263)	18	0	0	0	0	0	0	0	0	0	(245)	32
33	Real Estate Taxes	0	18	0	0	0	0	0	0	0	0	0	18	33
34	Rent-Facility & Grounds	0	0	6,299	0	0	0	0	0	0	0	0	6,299	34
35	Rent-Equipment & Vehicles	0	0	227	0	0	0	0	0	0	0	0	227	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(263)	2,111	6,526	0	0	0	0	0	0	0	0	8,374	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)**	(35,402)	(23,512)	6,526	0	0	0	0	0	0	0	0	(52,388)	45

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	St. Louis	Management Co.
				Helia Healthcare Services	Benton	Laundry, Maint., Se
				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	10	Nursing & Medical Records	$	Bridgemark Healthcare, L.L.C.	100.00%	$ 13,101	$ 13,101	1
2	V	17	Administrative	209,553	Bridgemark Healthcare, L.L.C.	100.00%	22,306	(187,247)	2
3	V	19	Professional Fees		Bridgemark Healthcare, L.L.C.	100.00%	4,384	4,384	3
4	V	20	Dues, Fees & Subscriptions		Bridgemark Healthcare, L.L.C.	100.00%	763	763	4
5	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, L.L.C.	100.00%	110,947	110,947	5
6	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, L.L.C.	100.00%	21,555	21,555	6
7	V	24	Travel & Seminars		Bridgemark Healthcare, L.L.C.	100.00%	1,053	1,053	7
8	V	25	Admin Staff Transportation		Bridgemark Healthcare, L.L.C.	100.00%	8,456	8,456	8
9	V	26	Insurance		Bridgemark Healthcare, L.L.C.	100.00%	1,365	1,365	9
10	V	30	Depreciation		Bridgemark Healthcare, L.L.C.	100.00%	2,075	2,075	10
11	V	32	Interest		Bridgemark Healthcare, L.L.C.	100.00%	18	18	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, L.L.C.	100.00%	18	18	12
13	V								13
14	Total			$ 209,553			$ 186,041	$ * (23,512)	14

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

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	34	Rent - Facility & Grounds	$	Bridgemark Healthcare, L.L.C.	100.00%	$ 6,299	$ 6,299	15
16	V	35	Equipment Rent		Bridgemark Healthcare, L.L.C.	100.00%	227	227	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			$			$ 6,526	$ * 6,526	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	277,694	4	7.44	Distribution	$ 22,306	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	$ 22,306		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 Hillside Rehab & Care Center # 0050310 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	23,505	$ 13,101	1
2	17	Owners Compensation	Resident Days	316,121	13	300,000		23,505	22,306	2
3	19	Professional Fees	Resident Days	316,121	13	58,959		23,505	4,384	3
4	20	Dues, Subscriptions	Resident Days	316,121	13	10,259		23,505	763	4
5	21	Salaries - Other	Resident Days	316,121	13	1,022,795	1,022,795	23,505	76,049	5
6	21	Clerical	Resident Days	316,121	13	469,344		23,505	34,898	6
7	22	Employee Benefits	Resident Days	316,121	13	289,889		23,505	21,555	7
8	24	Seminars	Resident Days	316,121	13	14,156		23,505	1,053	8
9	25	Admin Staff Travel	Resident Days	316,121	13	113,730		23,505	8,456	9
10	26	Insurance	Resident Days	316,121	13	18,353		23,505	1,365	10
11	30	Depreciation	Resident Days	316,121	13	27,905		23,505	2,075	11
12	32	Interest	Resident Days	316,121	13	242		23,505	18	12
13	33	Real Estate Taxes	Resident Days	316,121	13	241		23,505	18	13
14	34	Building Rent	Resident Days	316,121	13	83,985		23,505	6,245	14
15	34	Rental - Storage Unit	Resident Days	316,121	13	723		23,505	54	15
16	35	Equipment Rental	Resident Days	316,121	13	3,055		23,505	227	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		$ 192,567	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	3,226	6
7												7
8	Related Party Allocation - Bridgemark										18	8
9	TOTAL Facility Related						$	$			$ 3,244	9
	B. Non-Facility Related*											
10	Interest Income		X								(263)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (263)	14
15	TOTALS (line 9+line14)						$	$			$ 2,981	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 Hillside Rehab & Care Center # 0050310 **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.)		$ 88,150	2
3. Under or (over) accrual (line 2 minus line 1).		$ 88,150	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.		$ 88,150	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	67,078	8
2006	67,835	9
2007	75,653	10
2008	68,301	11
2009	69,651	12

88,150 Line 7, Real Estate Tax Portion of Lease Payment
18 Bridgemark Healthcare Allocation
88,168 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 Hillside Rehab & Care Center COUNTY Kendall

FACILITY IDPH LICENSE NUMBER 0050310

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.	02-29-278-001	Lot 1 unit 13 Countryside Sub	$ 64,119.30	$ 64,119.30
2.	02-29-278-008	Sec. 29-37-7	$ 2,583.38	$ 2,583.38
3.	02-29-278-015	Lot 12 Unit 1 & Lot 16 unit 2	$ 2,947.92	$ 2,947.92
4.		Countryside Sub	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,650.60	$ 69,650.60

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 Hillside Rehab & Care Center # 0050310 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,390 B. General Construction Type: Exterior Masonry Frame Brick 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	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Therapy Door			2009	1,630	109	15	109		172	9
10	Wallcovering, shower room remodel, nurses station, & entryway			2009	15,951	1,063	15	1,063		1,329	10
11	Carpet			2009	3,509	702	5	702		936	11
12	Concrete			2009	3,500	233	15	233		253	12
13	Carpet			2009	3,390	678	5	678		678	13
14											14
15	Hallway Wing 1-paint, crown molding			2010	5,752	352	15	352		352	15
16	Oak Wall Cabinets for Nurses Station			2010	1,163	65	15	65		65	16
17	Reception Area-countertop, paint, oakwork, drywall			2010	5,127	228	15	228		228	17
18	Shower Room W1-heater, fire system installation			2010	2,854	127	15	127		127	18
19	Shower Room W2-heater, fire system installation			2010	2,854	127	15	127		127	19
20	4 Ton A/C Unit & Install			2010	3,155	184	10	184		184	20
21	Carpet			2010	3,473	289	5	289		289	21
22	Concrete Work (Drainage: W1, W2, Main)			2010	7,000	117	20	117		117	22
23	Hallway Wing 2-paint, crown molding			2010	4,836	107	15	107		107	23
24	Facility Signage - in building			2010	3,725	62	10	62		62	24
25	Dining Room - Pain, tile, lights/blinds			2010	3,426	38	15	38		38	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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			$	$		$	$	$	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)		$ 71,345	$ 4,481		$ 4,481	$	$ 5,064	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	$ 16,565	$ 2,831	$ 4,210	$ 1,379	3-10	$ 8,449	71
72	Current Year Purchases	3,059	11	326	315	3-10	326	72
73	Fully Depreciated Assets	42					42	73
74								74
75	TOTALS	$ 19,666	$ 2,842	$ 4,536	$ 1,694		$ 8,817	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bridgemark Healthcare Allocation			$ 2,135	$	$ 381	$ 381	4	$ 1,202	76
77										77
78										78
79										79
80	TOTALS			$ 2,135	$	$ 381	$ 381		$ 1,202	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)	$ 93,146	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,323	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,398	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,075	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,083	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 Hillside Rehab & Care Center # 0050310 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: Elite Yorkville, 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:		79		$ 355,296			3
4	Additions							4
5	Related Party Allocation - Bridgemark				6,299			5
6	Storage Rental				972			6
7	TOTAL		79		$ 362,567 **			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: $ 39,725 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 Hillside Rehab & Care Center # 0050310 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 Hillside Rehab & Care Center STATE OF ILLINOIS # 0050310 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 2 & 3	hrs	$		$ 113,043	$ 781		$ 113,824	1
2	Licensed Speech and Language Development Therapist	10a, 2 & 3	hrs			98,199	382		98,581	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2 & 3	hrs			130,179	95		130,274	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				69,162		69,162	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound care, oxygen	39, 2					25,904		25,904	12
13	Other (specify): Lab, X-Ray, Other	39, 3				8,682			8,682	13
14	TOTAL			$		$ 350,103	$ 96,324		$ 446,427	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 Hillside Rehab & Care Center **#** 0050310 **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	$ 1,105	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 63,790)	310,074		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)	603,471		8
9	Other(specify): Deposits	58,150		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 974,383	$	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	71,345		15
16	Equipment, at Historical Cost	10,137		16
17	Accumulated Depreciation (book methods)	(9,645)		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 (spe CIP	2,648		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 74,485	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,048,868	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 317,179	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,347		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,328		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 455,854	$	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	Due to Prior Owner	1,411		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,411	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 457,265	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 591,603	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,048,868	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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**	$ 284,450	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 284,450	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	307,153	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)**	$ 307,153	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)**	$ 591,603	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	$ 4,010,472	1
2	Discounts and Allowances for all Levels	(38,094)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,972,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,034	6
7	Oxygen	1,118	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,152	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	263	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 263	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Utility Deposit Refund	4,321	28
28a	Miscellaneous Income	140	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,461	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,156,254	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	613,441	31
32	Health Care	1,791,645	32
33	General Administration	802,549	33
	B. Capital Expense		
34	Ownership	494,465	34
	C. Ancillary Expense		
35	Special Cost Centers	103,748	35
36	Provider Participation Fee	43,253	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,849,101	40
41	**Income before Income Taxes (line 30 minus line 40)****	307,153	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 307,153	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 Hillside Rehab & Care Center # 0050310 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	2,152	2,200	$ 68,774	$ 31.26	1
2	Assistant Director of Nursing	145	145	3,507	24.19	2
3	Registered Nurses	11,821	12,902	330,468	25.61	3
4	Licensed Practical Nurses	8,372	9,473	233,516	24.65	4
5	CNAs & Orderlies	45,218	47,994	560,592	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,560	2,666	38,069	14.28	10
11	Social Service Workers	2,376	2,445	52,122	21.32	11
12	Dietician					12
13	Food Service Supervisor	2,025	2,134	39,079	18.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,694	10,903	112,283	10.30	15
16	Dishwashers					16
17	Maintenance Workers	3,199	3,367	20,609	6.12	17
18	Housekeepers	9,962	10,953	121,048	11.05	18
19	Laundry	778	997	13,558	13.60	19
20	Administrator	2,027	2,080	90,261	43.39	20
21	Assistant Administrator					21
22	Other Administrative	1,974	2,101	26,669	12.69	22
23	Office Manager	1,875	2,006	31,199	15.55	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	1,643	1,774	42,804	24.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,821	114,140	$ 1,784,558 *	$ 15.63	34

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		$ 7,745	1, 3	35
36	Medical Director		8,400	9, 3	36
37	Medical Records Consultant		1,155	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,928	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		1,581	11, 3	44
45	Social Service Consultant		961	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,770		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judith Koczo	Administrator	0	$ 90,261
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,261

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 209,553
TOTAL (agree to Schedule V, line 17, col. 3)	$ 209,553
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company LLC	Accounting Services	$ 5,300
Ceridian	Payroll Processin	6,550
Much Shelist	Legal Fees	133
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 11,983

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,220
Unemployment Compensation Insurance	45,422
FICA Taxes	136,519
Employee Health Insurance	17,199
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,888
Related Party Allocation - Bridgemark	21,555
TOTAL (agree to Schedule V, line 22, col.8)	$ 307,803

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,265
Advertising: Employee Recruitment	12
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,276
Late Fees	362
Dues & Subscriptions	4,029
Misc. Fees & Licenses	399
Related Party Allocation - Bridgemark	763
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,106

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	732
Seminar Expense	407
Related Party Allocation - Bridgemark	1,053
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,192

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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 $2,943**

(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? **3-5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,683** 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. $ **43,253**
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. $ **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? **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

Hillside Rehab & Care Center
Attachment to Schedule VII A
Related Nursing Home
40543

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

Hillside Rehab & Care Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2010

	Description	
16A	Nursing Equipment Rental	$ 37,336
16B	Copier Lease	2,162
16C	Related Party Allocation - Bridgemark	227
		$ 39,725