

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>I. IDPH License ID Number: <u>0048827</u></p> <p>Facility Name: <u>Helia Healthcare of Belleville</u></p> <p>Address: <u>40 North 64th Street</u> <u>Belleville</u> <u>62223</u> Number City Zip Code</p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: <u>(618) 397-8400</u> Fax # <u>(618) 397-8470</u></p> <p>HFS ID Number: <u>208125439001</u></p> <p>Date of Initial License for Current Owners: <u>06/01/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Michael Parentin</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>See Accountants' Compilation Report</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Cindy A. Tefteller</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, LLC</u> <u>233 East Center Drive, Alton, IL 62002</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Michael Parentin</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) <u>See Accountants' Compilation Report</u>	(Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u>		(Firm Name & Address) <u>C.J. Schlosser & Company, LLC</u> <u>233 East Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Belleville

0048827 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	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	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	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	<u>25,435</u>	<u>882</u>	<u>8,580</u>	<u>34,897</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,435</u>	<u>882</u>	<u>8,580</u>	<u>34,897</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.37%

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

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

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

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

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 12/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/07 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 122 and days of care provided 4,092

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Helia Healthcare of Belleville # 0048827 Report Period Beginning: 1/1/09 Ending: 12/31/09

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
	A. General Services										
1	Dietary	182,321	13,069	11,335	206,725		206,725		206,725		1
2	Food Purchase		122,081		122,081		122,081	(75)	122,006		2
3	Housekeeping	100,407	27,356		127,763		127,763		127,763		3
4	Laundry	62,424	14,655		77,079		77,079		77,079		4
5	Heat and Other Utilities			119,906	119,906		119,906	129	120,035		5
6	Maintenance	51,712	14,480	83,270	149,462		149,462		149,462		6
7	Other (specify):*										7
8	TOTAL General Services	396,864	191,641	214,511	803,016		803,016	54	803,070		8
	B. Health Care and Programs										
9	Medical Director			32,400	32,400		32,400		32,400		9
10	Nursing and Medical Records	1,891,919	249,588	1,863	2,143,370	2,500	2,145,870	22,129	2,167,999		10
10a	Therapy	565,837	133,680	483,511	1,183,028		1,183,028		1,183,028		10a
11	Activities	79,923	10,136	3,001	93,060		93,060	(1,537)	91,523		11
12	Social Services	65,363	103	2,847	68,313		68,313		68,313		12
13	CNA Training										13
14	Program Transportation			6,516	6,516		6,516		6,516		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,603,042	393,507	530,138	3,526,687	2,500	3,529,187	20,592	3,549,779		16
	C. General Administration										
17	Administrative	67,000		380,168	447,168		447,168	(318,810)	128,358		17
18	Directors Fees										18
19	Professional Services			20,385	20,385		20,385	5,632	26,017		19
20	Dues, Fees, Subscriptions & Promotions			49,147	49,147		49,147	(29,360)	19,787		20
21	Clerical & General Office Expenses	179,835	31,778	54,557	266,170		266,170	58,474	324,644		21
22	Employee Benefits & Payroll Taxes			525,069	525,069		525,069	33,001	558,070		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,002	4,002	(2,500)	1,502	909	2,411		24
25	Other Admin. Staff Transportation			4,888	4,888		4,888	15,735	20,623		25
26	Insurance-Prop.Liab.Malpractice			106,383	106,383		106,383	1,073	107,456		26
27	Other (specify):*										27
28	TOTAL General Administration	246,835	31,778	1,144,599	1,423,212	(2,500)	1,420,712	(233,346)	1,187,366		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,246,741	616,926	1,889,248	5,752,915		5,752,915	(212,700)	5,540,215		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Belleville

#0048827

Report Period Beginning:

1/1/09

Ending:

12/31/09

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			7,215	7,215		7,215	2,398	9,613			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,361	53,361		53,361	(53,361)				32
33	Real Estate Taxes			86,100	86,100		86,100	451	86,551			33
34	Rent-Facility & Grounds			558,941	558,941		558,941	11,164	570,105			34
35	Rent-Equipment & Vehicles			233,937	233,937		233,937	356	234,293			35
36	Other (specify):*											36
37	TOTAL Ownership			939,554	939,554		939,554	(38,992)	900,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		542,487	36,745	579,232		579,232		579,232			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		542,487	103,540	646,027		646,027		646,027			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,246,741	1,159,413	2,932,342	7,338,496		7,338,496	(251,692)	7,086,804			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,537)	11		4
5	Telephone, TV & Radio in Resident Rooms				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	(53,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	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				17
18	Fines and Penalties	(6,055)	21		18
19	Entertainment	(3,916)	21		19
20	Contributions	(1,100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,316)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,023)	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	(67,543)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (159,926)		\$	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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(91,766)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (91,766)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (251,692)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

Helia Healthcare of Belleville

ID# 0048827

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To eliminate gifts & flowers	\$ (4,101)	20	1
2	To eliminate Marketing Salaries	(57,996)	21	2
3	To eliminate Collection Fees	(2,554)	21	3
4	To eliminate Medical Record Copies	(2,306)	10	4
5	To eliminate PAC Dues	(586)	20	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
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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	(67,543)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Belleville# 0048827

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(75)	0	0	0	0	0	0	0	0	0	0	(75)	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	0	129	0	0	0	0	0	0	0	0	0	129	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	(75)	129	0	54	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	(2,306)	24,435	0	0	0	0	0	0	0	0	0	22,129	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,537)	0	0	0	0	0	0	0	0	0	0	(1,537)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,843)	24,435	0	20,592	16								
	C. General Administration													
17	Administrative	0	(318,810)	0	0	0	0	0	0	0	0	0	(318,810)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,316)	6,948	0	0	0	0	0	0	0	0	0	5,632	19
20	Fees, Subscriptions & Promotions	(29,710)	350	0	0	0	0	0	0	0	0	0	(29,360)	20
21	Clerical & General Office Expenses	(71,621)	130,095	0	0	0	0	0	0	0	0	0	58,474	21
22	Employee Benefits & Payroll Taxes	0	33,001	0	0	0	0	0	0	0	0	0	33,001	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	909	0	0	0	0	0	0	0	0	0	909	24
25	Other Admin. Staff Transportation	0	15,735	0	0	0	0	0	0	0	0	0	15,735	25
26	Insurance-Prop.Liab.Malpractice	0	1,073	0	0	0	0	0	0	0	0	0	1,073	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(102,647)	(130,699)	0	(233,346)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,565)	(106,135)	0	(212,700)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Belleville# 0048827

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	2,398	0	0	0	0	0	0	0	0	0	2,398	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(53,361)	0	0	0	0	0	0	0	0	0	0	(53,361)	32
33	Real Estate Taxes	0	0	451	0	0	0	0	0	0	0	0	451	33
34	Rent-Facility & Grounds	0	11,164	0	0	0	0	0	0	0	0	0	11,164	34
35	Rent-Equipment & Vehicles	0	356	0	0	0	0	0	0	0	0	0	356	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(53,361)	13,918	451	0	(38,992)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(159,926)	(92,217)	451	0	(251,692)	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 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. 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	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 129	\$	129	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	24,435		24,435	2
3	V	17 Management Fees	380,168	Bridgemark Healthcare, LLC	100.00%	61,358		(318,810)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	6,948		6,948	4
5	V	20 Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	350		350	5
6	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	130,095		130,095	6
7	V	22 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	33,001		33,001	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	909		909	8
9	V	25 Other Admin Transportation		Bridgemark Healthcare, LLC	100.00%	15,735		15,735	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,073		1,073	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	2,398		2,398	11
12	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	11,164		11,164	12
13	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	356		356	13
14	Total		\$ 380,168			\$ 287,951	\$ *	(92,217)	14

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

Facility Name & ID Number Helia Healthcare of Belleville

0048827

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	33 Real Estate Taxes	\$	Bridgemark Healthcare, LLC	100.00%	\$ 451	\$	451	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		\$			\$ 451	\$ *	451	39

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

Facility Name & ID Number Helia Healthcare of Belleville # 0048827 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	418,642	6	12.78	Distribution	\$ 61,358	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	\$ 61,358		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 Belleville

0048827

Report Period Beginning:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	272,995	11	\$ 191,151	\$ 191,151	34,897	\$ 24,435	1
2	17	Owners Compensation	Resident Days	272,995	11	480,000		34,897	61,358	2
3	19	Professional Fees	Resident Days	272,995	11	54,354		34,897	6,948	3
4	20	Dues, Subscriptions	Resident Days	272,995	11	2,735		34,897	350	4
5	21	Clerical	Resident Days	272,995	11	1,017,715	852,724	34,897	130,095	5
6	22	Employee Benefits	Resident Days	272,995	11	258,166		34,897	33,001	6
7	24	Seminars	Resident Days	272,995	11	7,110		34,897	909	7
8	25	Admin Staff Travel	Resident Days	272,995	11	123,093		34,897	15,735	8
9	26	Insurance	Resident Days	272,995	11	8,392		34,897	1,073	9
10	30	Depreciation	Resident Days	272,995	11	18,757		34,897	2,398	10
11	35	Equipment Rental	Resident Days	272,995	11	2,787		34,897	356	11
12	34	Rent	Resident Days	272,995	11	83,890		34,897	10,724	12
13	34	Rental - Storage Unit	Resident Days	272,995	11	3,444		34,897	440	13
14	5	Utilities	Resident Days	272,995	11	1,007		34,897	129	14
15	33	Real Estate Taxes	Resident Days	272,995	11	3,528		34,897	451	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,256,129	\$ 1,043,875		\$ 288,402	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Belleville

0048827

Report Period Beginning:

1/1/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Plasterers		2007	6,731	337	20	337		1,010
10	A/C Units		2007	1,072	214	5	214		642
11	Water Heater		2007	2,945	589	5	589		1,767
12	Air Units		2007	1,215	121	10	121		364
13	Supplies for Sign		2007	1,060	106	10	106		318
14	100 Gal. Water Heater		2008	8,183	818	10	818		1,363
15	Vanities		2008	810	81	10	81		162
16	Windows		2008	1,065	53	20	53		71
17	Sprinklers		2008	7,898	527	15	527		659
18	Asphalt for Rear of Building		2008	2,085	261	8	261		283
19	New Water Pump		2008	1,439	144	10	144		156
20									
21	New Nurse's Station & renovation of front entrance & hallways		2009	35,615	907	15	907		907
22	Asphalt for Front of Building		2009	1,295	67	8	67		67
23	Cabinets		2009	3,965	88	15	88		88
24	Carpet		2009	9,553	637	5	637		637
25	14 Doors		2009	4,382	49	15	49		49
26	Water Heater		2009	4,415	74	10	74		74
27	Cable Installation		2009	8,031	67	10	67		67
28									
29									
30									
31									
32									
33									
34									
35									
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

Facility Name & ID Number Helia Healthcare of Belleville

0048827

Report Period Beginning:

1/1/09

Ending:

12/31/09

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
			101,759		5,140		5,140	
							8,684	

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 18,815	\$ 1,694	\$ 3,426	\$ 1,732	5-10	\$ 7,582	71
72	Current Year Purchases	12,831	381	568	187	5-10	568	72
73	Fully Depreciated Assets	72					72	73
74								74
75	TOTALS	\$ 31,718	\$ 2,075	\$ 3,994	\$ 1,919		\$ 8,222	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			\$ 3,671	\$	\$ 479	\$ 479	4	\$ 1,411	76
77										77
78										78
79										79
80	TOTALS			\$ 3,671	\$	\$ 479	\$ 479		\$ 1,411	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)	\$ 137,148	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,613	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,398	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,317	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Belleville Illinois, LLC

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>122</u>		\$ <u>558,941</u>			3
4	Additions						4
5							5
6	<u>Related Party Allocation - Bridgemark</u>			<u>11,164</u>			6
7	TOTAL	122		\$ <u>570,105</u>			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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: \$ 234,293 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	TOTAL		\$ _____	\$ _____	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	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**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$		\$ 189,587	\$		\$ 189,587	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			80,052			80,052	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			213,872	1,816		215,688	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	10a-01	hrs							8
9	Pharmacy	39-02	# of prescripts				288,120		288,120	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab & X-Rays</u>	39-03				36,745			36,745	12
13	Other (specify): <u>R.T., Wound, Enterals</u>	10a1&2, 39-02		448,568			386,232		834,800	13
14	TOTAL			\$ 448,568		\$ 520,256	\$ 676,168		\$ 1,644,992	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 Belleville**# **0048827**Report Period Beginning: **1/1/09**Ending: **12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(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	\$ 7,293	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>206,967</u>)	1,296,018		3
4	Supply Inventory (priced at <u>Cost</u>)	3,717		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,553		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	135,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,456,581	\$	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	95,467		15
16	Equipment, at Historical Cost	26,514		16
17	Accumulated Depreciation (book methods)	(12,020)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 109,961	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,566,542	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 812,930	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	199,811		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,006		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	<u>Due to Prior Owner</u>	1,940		36
37	<u>Deferred Rent</u>	102,089		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,125,776	\$	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	<u>Due to Related Party</u>	19,563		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,563	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,145,339	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 421,203	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,566,542	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 151,659	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 151,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	269,544	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)	\$ 269,544	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)	\$ 421,203	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Belleville# 0048827Report Period Beginning: 1/1/09Ending: 12/31/09

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,386,821	1
2	Discounts and Allowances for all Levels	(175,451)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,211,370	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	171,364	6
7	Oxygen	139,613	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 310,977	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	1,537	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)	\$ 1,537	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	76,008	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 76,008	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	8,148	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,148	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,608,040	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	803,016	31
32	Health Care	3,526,687	32
33	General Administration	1,423,212	33
B. Capital Expense			
34	Ownership	939,554	34
C. Ancillary Expense			
35	Special Cost Centers	579,232	35
36	Provider Participation Fee	66,795	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,338,496	40
41	Income before Income Taxes (line 30 minus line 40)**	269,544	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 269,544	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Belleville

0048827

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	1,935	2,120	\$ 64,304	\$ 30.33	1
2	Assistant Director of Nursing	1,914	2,083	62,363	29.94	2
3	Registered Nurses	7,235	7,744	206,503	26.67	3
4	Licensed Practical Nurses	27,589	30,030	640,160	21.32	4
5	CNAs & Orderlies	62,051	67,810	749,431	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,058	6,730	117,269	17.42	8
9	Activity Director					9
10	Activity Assistants	4,282	4,751	79,923	16.82	10
11	Social Service Workers	2,932	3,120	65,363	20.95	11
12	Dietician					12
13	Food Service Supervisor	2,164	2,292	37,946	16.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,269	15,672	144,375	9.21	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,080	51,712	24.86	17
18	Housekeepers	8,996	9,718	100,407	10.33	18
19	Laundry	6,996	7,398	62,424	8.44	19
20	Administrator	2,080	2,080	67,000	32.21	20
21	Assistant Administrator					21
22	Other Administrative	8,268	8,698	132,623	15.25	22
23	Office Manager	1,924	2,391	47,212	19.75	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	2,557	2,709	43,908	16.21	31
32	Other Health C: Respiratory	18,517	19,684	448,568	22.79	32
33	Other(specify) CP, IC, MDS, CS	7,896	8,335	125,250	15.03	33
34	TOTAL (lines 1 - 33)	189,631	205,445	\$ 3,246,741 *	\$ 15.80	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	Monthly	\$ 11,335	01-03	35
36	Medical Director	Monthly	32,400	09-03	36
37	Medical Records Consultant	Monthly	704	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,159	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	3,001	11-03	44
45	Social Service Consultant	51	2,847	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	105	\$ 51,446		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mark Warren	Administrator	0.00	\$ 67,000	Workers' Compensation Insurance	\$ 139,141	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	51,125	Advertising: Employee Recruitment	3,020	
				FICA Taxes	248,376	Health Care Worker Background Check		
				Employee Health Insurance	81,147	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	3,000	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	10,126	
				401(k) Match	5,280	Related Party Allocation - Bridgemark	350	
						Late Fees	360	
TOTAL (agree to Schedule V, line 17, col. 1)				Related Party Allocation - Bridgemark	33,001	Administrators License		
(List each licensed administrator separately.)			\$ 67,000			Misc. Licenses, Permits & Certifications	1,936	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Bridgemark Healthcare Services - Management Fee			\$ 380,168			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 380,168	TOTAL (agree to Schedule V, line 22, col.8)	\$ 558,070	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,787	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C.J. Schlosser & Co.	Accounting Services		\$ 4,270	Section N/A		\$	Out-of-State Travel	\$
Ceridian	Payroll Processing		10,209					
Midwest Time Recorder	Payroll Processing		575					
Kramer & Frank	Collection Fees(Nonallowable)		1,316				In-State Travel	207
Arnstein & Lehr	Legal Fees		1,308					
Greensfelder	Legal Fees		1,875					
Hepler, Broom, MacDonald	Legal Fees		150				Seminar Expense	1,295
Weltman, Weisberg & Reis Co	Legal Fees		682				Related Party Allocation - Bridgemark	909
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 20,385				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,411

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Belleville# 0048827Report Period Beginning: 1/1/09Ending: 12/31/09**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 \$6,734
- (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. \$ 53,814 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. \$ 66,795
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A 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 Belleville
Attachment to Schedule VII A
Related Nursing Homes
12/31/2009

Helia Healthcare of Benton
Helia Healthcare of Carbondale
Helia Healthcare of Champaign
Helia Healthcare of Energy
Helia Healthcare of Urbana
Helia Healthcare of Greenville
Frankfort Healthcare & Rehab Center
Helia Southbelt Heathcare
Helia Healthcare of Zion
Hillside Rehab & Care Center

Helia Healthcare of Belleville
Attachment to Schedule XII B
Equipment Rentals
12/31/2009

<u>Description</u>			
16A	Specialty Bed Rental	\$	231,868
16B	Respiratory Equipment		2,069
16C	Related Party Allocation - Bridgemark		356
		<u>\$</u>	<u>234,293</u>

Helia Healthcare of Belleville
Attachment to Schedule XVII E
Other Revenue
12/31/2009

Description			
28A	Medical Record Copies	\$	2,306
28B	Recovery of Bad Debt		4,250
28C	Gain on Sale		1,456
28D	Miscellaneous Income		136
		<u>\$</u>	<u>8,148</u>