		FOR BHF USE					

LL1

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.

I. IDPH License ID Number: 0049775

Facility Name: Helia Healthcare of Benton

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

County: Franklin

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

HFS ID Number: 510453697001

Date of Initial License for Current Owners: 8/15/08

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/09 to 12/31/09 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, LLC 233 East Center Drive, Alton, IL 62002
	(Telephone)	(618) 465-7717 Fax # (618) 465-7710

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 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	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,629	5,670	6,642	25,941	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,629	5,670	6,642	25,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.63%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 6,155

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 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	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	97,846	6,795	91,437	196,078		196,078		196,078			1
2	Food Purchase		183,976		183,976		183,976	(199)	183,777			2
3	Housekeeping	89,453	31,730		121,183		121,183		121,183			3
4	Laundry	162	15,056	41,506	56,724		56,724	14,950	71,674			4
5	Heat and Other Utilities			96,148	96,148		96,148	10,852	107,000			5
6	Maintenance	37,017	11,677	36,390	85,084		85,084	(697)	84,387			6
7	Other (specify):*											7
8	**TOTAL General Services**	224,478	249,234	265,481	739,193		739,193	24,906	764,099			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,064,430	73,737	3,635	1,141,802		1,141,802	18,164	1,159,966			10
10a	Therapy			542,464	542,464		542,464		542,464			10a
11	Activities	28,621	7,808	2,066	38,495		38,495		38,495			11
12	Social Services	26,873		1,705	28,578		28,578		28,578			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,119,924	81,545	561,870	1,763,339		1,763,339	18,164	1,781,503			16
	C. General Administration											
17	Administrative	71,345		219,094	290,439		290,439	(173,483)	116,956			17
18	Directors Fees											18
19	Professional Services			10,258	10,258		10,258	5,961	16,219			19
20	Dues, Fees, Subscriptions & Promotions			42,527	42,527		42,527	(31,132)	11,395			20
21	Clerical & General Office Expenses	42,013	18,955	59,678	120,646		120,646	107,714	228,360			21
22	Employee Benefits & Payroll Taxes			257,559	257,559		257,559	34,293	291,852			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,260	1,260		1,260	464	1,724			24
25	Other Admin. Staff Transportation			8,907	8,907		8,907	25,504	34,411			25
26	Insurance-Prop.Liab.Malpractice			76,955	76,955		76,955	1,321	78,276			26
27	Other (specify):*											27
28	**TOTAL General Administration**	113,358	18,955	676,238	808,551		808,551	(29,358)	779,193			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,457,760	349,734	1,503,589	3,311,083		3,311,083	13,712	3,324,795			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton #0049775 Report Period Beginning: 1/1/09 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,659	9,659		9,659	14,338	23,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							13,979	13,979			32
33	Real Estate Taxes			24,000	24,000		24,000	3,744	27,744			33
34	Rent-Facility & Grounds			302,950	302,950		302,950	(289,651)	13,299			34
35	Rent-Equipment & Vehicles			52,752	52,752		52,752	265	53,017			35
36	Other (specify):*											36
37	TOTAL Ownership			389,361	389,361		389,361	(257,325)	132,036			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,493	78,411	314,904		314,904		314,904			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,443	45,443		45,443		45,443			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		236,493	123,854	360,347		360,347		360,347			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,457,760	586,227	2,016,804	4,060,791		4,060,791	(243,613)	3,817,178			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,870)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,068)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	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	(1,306)	21		18
19	Entertainment	(988)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(210)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,056)	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	(12,822)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,519)		$	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)	(201,094)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (201,094)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (243,613)		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

STATE OF ILLINOIS

Helia Healthcare of Benton

ID# 0049775

Report Period Beginning: 1/1/09

Ending: 12/31/09

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts and Flowers	$ (9,940)	20	1
2	To offset Dues/Subscriptions reimbursement	(10)	20	2
3	To eliminate fees associated with collections	(2,262)	21	3
4	To eliminate PAC payment recorded in travel/seminar	(212)	24	4
5	To eliminate PAC Dues	(398)	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
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**	(12,822)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Benton # 0049775 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(199)	0	0	0	0	0	0	0	0	0	0	(199)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	14,950	0	0	0	0	0	0	0	0	0	14,950	4
5	Heat and Other Utilities	(4,870)	15,626	96	0	0	0	0	0	0	0	0	10,852	5
6	Maintenance	0	(697)	0	0	0	0	0	0	0	0	0	(697)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,069)	29,879	96	0	0	0	0	0	0	0	0	24,906	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	18,164	0	0	0	0	0	0	0	0	18,164	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	18,164	0	0	0	0	0	0	0	0	18,164	16
	C. General Administration													
17	Administrative	0	0	(173,483)	0	0	0	0	0	0	0	0	(173,483)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(210)	1,006	5,165	0	0	0	0	0	0	0	0	5,961	19
20	Fees, Subscriptions & Promotions	(31,404)	12	260	0	0	0	0	0	0	0	0	(31,132)	20
21	Clerical & General Office Expenses	(4,556)	15,563	96,707	0	0	0	0	0	0	0	0	107,714	21
22	Employee Benefits & Payroll Taxes	0	9,761	24,532	0	0	0	0	0	0	0	0	34,293	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(212)	0	676	0	0	0	0	0	0	0	0	464	24
25	Other Admin. Staff Transportation	0	13,807	11,697	0	0	0	0	0	0	0	0	25,504	25
26	Insurance-Prop.Liab.Malpractice	0	524	797	0	0	0	0	0	0	0	0	1,321	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,382)	40,673	(33,649)	0	0	0	0	0	0	0	0	(29,358)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,451)	70,552	(15,389)	0	0	0	0	0	0	0	0	13,712	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Benton # 0049775 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	4,315	10,023	0	0	0	0	0	0	0	0	14,338	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,068)	14,449	598	0	0	0	0	0	0	0	0	13,979	32
33	Real Estate Taxes	0	3,409	335	0	0	0	0	0	0	0	0	3,744	33
34	Rent-Facility & Grounds	0	0	(289,651)	0	0	0	0	0	0	0	0	(289,651)	34
35	Rent-Equipment & Vehicles	0	0	265	0	0	0	0	0	0	0	0	265	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,068)	22,173	(278,430)	0	0	0	0	0	0	0	0	(257,325)	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)	(42,519)	92,725	(293,819)	0	0	0	0	0	0	0	0	(243,613)	45

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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. Ser
				Bridgemark Employer Services	St. Louis	Human Resources
				Bridgemark Medical Supply	St. Louis	Medical Supplie

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Laundry	$ 41,506	Helia Healthcare Services	100.00%	$ 56,456	$ 14,950	1
2	V	5	Utilities		Helia Healthcare Services	100.00%	15,626	15,626	2
3	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	2,303	(697)	3
4	V	19	Professional Services		Helia Healthcare Services	100.00%	1,006	1,006	4
5	V	20	Dues, Fees, & Subscriptions		Helia Healthcare Services	100.00%	12	12	5
6	V	21	Clerical		Helia Healthcare Services	100.00%	15,563	15,563	6
7	V	22	Employee Benefits		Helia Healthcare Services	100.00%	9,761	9,761	7
8	V	25	Admin Staff Travel		Helia Healthcare Services	100.00%	13,807	13,807	8
9	V	26	Insurance		Helia Healthcare Services	100.00%	524	524	9
10	V	30	Depreciation		Helia Healthcare Services	100.00%	4,315	4,315	10
11	V	32	Interest		Helia Healthcare Services	100.00%	14,449	14,449	11
12	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,409	3,409	12
13	V								13
14	Total			$ 44,506			$ 137,231	$ * 92,725	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 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. [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	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	5	Utilites	$	Bridgemark Healthcare, LLC	100.00%	$ 96	$ 96	15
16	V	10	Nursing & Med		Bridgemark Healthcare, LLC	100.00%	18,164	18,164	16
17	V	17	Management Fees	219,094	Bridgemark Healthcare, LLC	100.00%	45,611	(173,483)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	5,165	5,165	18
19	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	260	260	19
20	V	21	Clerical		Bridgemark Healthcare, LLC	100.00%	96,707	96,707	20
21	V	22	Employee Benefits		Bridgemark Healthcare, LLC	100.00%	24,532	24,532	21
22	V	24	Seminars		Bridgemark Healthcare, LLC	100.00%	676	676	22
23	V	25	Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	11,697	11,697	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	797	797	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,782	1,782	25
26	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	265	265	26
27	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	8,299	8,299	27
28	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	335	335	28
29	V								29
30	V								30
31	V								31
32	V	30	Depreciation		BM Properties I - Benton		8,241	8,241	32
33	V	32	Interest		BM Properties I - Benton		598	598	33
34	V	34	Rent	302,950	BM Properties I - Benton		5,000	(297,950)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 522,044			$ 228,225	$ * (293,819)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	434,389	5	9.50	Distribution	$ 45,611	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	$ 45,611		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 Benton # 0049775 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 [X] 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 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	5	Utilities	Resident Days	272,995	11	$ 1,007	$	25,941	$ 96	1
2	10	Nursing & Medical Records	Resident Days	272,995	11	191,151	191,151	25,941	18,164	2
3	17	Owners Compensation	Resident Days	272,995	11	480,000		25,941	45,611	3
4	19	Professional Fees	Resident Days	272,995	11	54,354		25,941	5,165	4
5	20	Dues, Subscriptions	Resident Days	272,995	11	2,735		25,941	260	5
6	21	Clerical	Resident Days	272,995	11	1,017,715	852,724	25,941	96,707	6
7	22	Employee Benefits	Resident Days	272,995	11	258,166		25,941	24,532	7
8	24	Seminars	Resident Days	272,995	11	7,110		25,941	676	8
9	25	Admin Staff Travel	Resident Days	272,995	11	123,093		25,941	11,697	9
10	26	Insurance	Resident Days	272,995	11	8,392		25,941	797	10
11	30	Depreciation	Resident Days	272,995	11	18,757		25,941	1,782	11
12	35	Equiment Rent	Resident Days	272,995	11	2,787		25,941	265	12
13	34	Rent	Resident Days	272,995	11	83,890		25,941	7,972	13
14	34	Rental - Storage Unit	Resident Days	272,995	11	3,444		25,941	327	14
15	33	Real Estate Taxes	Resident Days	272,995	11	3,528		25,941	335	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		$ 214,386	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry	Revenue	156,666	4	$ 198,732	$ 139,247	44,506	$ 56,456	1
2	5	Utilities	Revenue	156,666	4	55,005		44,506	15,626	2
3	6	Maintenance	Revenue	156,666	4	8,108	1,462	44,506	2,303	3
4	19	Professional Services	Revenue	156,666	4	3,541		44,506	1,006	4
5	20	Dues, Fees, & Subscriptions	Revenue	156,666	4	44		44,506	12	5
6	21	Clerical & Office Supplies	Revenue	156,666	4	54,785	48,744	44,506	15,563	6
7	22	Payroll Taxes & Emp. Ben.	Revenue	156,666	4	34,361		44,506	9,761	7
8	25	Other Admin Transp	Revenue	156,666	4	48,601		44,506	13,807	8
9	26	Insurance	Revenue	156,666	4	1,844		44,506	524	9
10	30	Depreciation	Revenue	156,666	4	15,191		44,506	4,315	10
11	32	Interest	Revenue	156,666	4	50,861		44,506	14,449	11
12	33	Real Estate Taxes	Revenue	156,666	4	12,000		44,506	3,409	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	TOTALS					$ 483,073	$ 189,453		$ 137,231	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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												6
7	Addition of BM Prop I Interest										598	7
8	Helia Healthcare Allocation										14,449	8
9	TOTAL Facility Related						$	$			$ 15,047	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,068)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,068)	14
15	TOTALS (line 9+line14)						$	$			$ 13,979	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.	$ 9,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$ (9,000)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 33,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 24,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
2004			8
2005			9
2006			10
2007	See note on		11
2008	Tax statement		12

24,000	Line 7, Estimate of property taxes once the county separates the parcel to Bridgemark
3,409	Helia Healthcare Allocation
335	Bridgemark Healthcare Allocation
27,744	Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

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

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Related Party Helia Healthcare Allocation			$ 5,556	1
2					2
3	TOTALS			$ 5,556	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Helia Healthcare Allocation		2006		$ 45,709	$	25	$ 1,777	$ 1,777	$ 4,331	4
5	83		2008		134,098		30	4,470	4,470	6,332	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221	75	15	75		75	9
10	Exterior Sign			2009	5,265	439	10	439		439	10
11	Landscaping			2009	4,135	310	10	310		310	11
12	Wallcoverings for hallways & entranceway, doors, shower remodel			2009	11,252	250	15	250		250	12
13	Carpet			2009	1,170	78	5	78		78	13
14	Nurse's Station Remodel/Wiring			2009	2,556	43	15	43		43	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

*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 Benton # 0049775 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation - Helia Healthcare		$	$		$	$	$	37
38	Water & Sewer Pipe Installation	2006	540		20	27	27	92	38
39	Plumbing & Heating Installation	2006	646		20	32	32	111	39
40	A/C Unit - 4 Ton	2007	1,557		10	156	156	415	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)		$ 208,149	$ 1,195		$ 7,657	$ 6,462	$ 12,476	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	$ 95,147	$ 7,486	$ 14,642	$ 7,156	3-5	$ 43,346	71
72	Current Year Purchases	15,693	978	1,117	139	5	1,117	72
73	Fully Depreciated Assets	15,130					15,130	73
74								74
75	TOTALS	$ 125,970	$ 8,464	$ 15,759	$ 7,295		$ 59,593	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bridgemark Healthcare Allocation		2005	$ 2,729	$	$ 356	$ 356	5	$ 1,049	76
77	Helia Healthcare Allocation		2006	628		225	225	5	482	77
78										78
79										79
80	TOTALS			$ 3,357	$	$ 581	$ 581		$ 1,531	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)	$ 343,032	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,659	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,997	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,338	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 73,600	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2010	$
13.	/2011	$
14.	/2012	$

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: $ 53,017 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	$		$ 223,781	$		$ 223,781	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			67,707			67,707	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			242,357			242,357	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				191,535		191,535	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39-03				78,411			78,411	12
13	Other (specify): Wound Care, Oxy, Ent	39-02					44,958		44,958	13
14	TOTAL			$		$ 612,256	$ 236,493		$ 848,749	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 Benton # 0049775 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	$ 2,450	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 82,670)	684,284		3
4	Supply Inventory (priced at Cost)	3,025		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,472		7
8	Accounts Receivable (owners or related parties)	1,133,978		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,838,209	$	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	25,599		15
16	Equipment, at Historical Cost	69,060		16
17	Accumulated Depreciation (book methods)	(46,485)		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)**	$ 48,174	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,886,383	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 557,433	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,200		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,465		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 654,098	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	65,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	123,729		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 188,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 842,827	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,043,556	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,886,383	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 753,360	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 753,360	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	290,196	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)**	$ 290,196	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,043,556	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,203,139	1
2	Discounts and Allowances for all Levels	(33,367)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,169,772	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,734	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 178,734	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,068	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,068	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	1,413	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,413	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,350,987	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	739,193	31
32	Health Care	1,763,339	32
33	General Administration	808,551	33
	B. Capital Expense		
34	Ownership	389,361	34
	C. Ancillary Expense		
35	Special Cost Centers	314,904	35
36	Provider Participation Fee	45,443	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,060,791	40
41	**Income before Income Taxes (line 30 minus line 40)****	290,196	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 290,196	43

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

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

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

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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 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	2,032	2,080	$ 75,561	$ 36.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,861	8,247	173,453	21.03	3
4	Licensed Practical Nurses	15,465	16,216	250,206	15.43	4
5	CNAs & Orderlies	52,117	53,954	480,741	8.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	811	895	7,114	7.95	8
9	Activity Director					9
10	Activity Assistants	2,454	2,494	28,621	11.48	10
11	Social Service Workers	2,064	2,080	26,873	12.92	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,080	34,446	16.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,132	7,566	63,400	8.38	15
16	Dishwashers					16
17	Maintenance Workers	3,397	3,448	37,017	10.74	17
18	Housekeepers	10,002	10,625	89,453	8.42	18
19	Laundry	20	20	162	8.10	19
20	Administrator	2,080	2,080	71,345	34.30	20
21	Assistant Administrator					21
22	Other Administrative	1,144	1,144	11,341	9.91	22
23	Office Manager	2,064	2,080	30,672	14.75	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	2,064	2,080	27,493	13.22	31
32	Other Health C: MDS	2,147	2,211	37,385	16.91	32
33	Other(specify) Care Plan	814	831	12,477	15.01	33
34	TOTAL (lines 1 - 33)	115,732	120,131	$ 1,457,760 *	$ 12.13	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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		$		35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	29	1,367	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	39	2,268	10-03	39
40	Physical Therapy Consultant	177	8,619	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	2,066	11-03	44
45	Social Service Consultant	31	1,705	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	313	$ 28,025		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

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandy McCoy	Administrator	0	$ 71,345
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 71,345

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 219,094
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 219,094

C. Professional Services

Vendor/Payee	Type	Amount
Ceridian	Payroll Processing	$ 7,168
Kramer & Frank	Collection Fees *	210
Craig & Craig	Legal Fees	1,842
Ashman & Stein	Legal Fees	1,032
Miscellaneous	Legal Fees	6
* Eliminated		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,258

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,100
Unemployment Compensation Insurance	32,359
FICA Taxes	111,519
Employee Health Insurance	50,162
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	1,419
Related Party Allocation - Bridgemark	24,532
Related Party Allocation - Helia	9,761
TOTAL (agree to Schedule V, line 22, col.8)	$ 291,852

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,182
Health Care Worker Background Check (Indicate # of checks performed ____)	
Patient Background Checks	1,888
Dues & Subscriptions	6,359
Late Fees	39
Misc Taxes & Licenses	660
Related Party Allocation - Bridgemark	260
Related Party Allocation - Helia	12
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,395

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	196
Seminar Expense	852
Related Party Allocation - Bridgemark	676
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,724

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 1/1/09 Ending: 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 $4,582**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,419** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **45,443**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Benton
Attachment to Schedule VII A
Related Nursing Homes
12/31/2009

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

	Description		
16A	Nursing Equipment Rental	$	49,389
16B	Copier Lease		3,363
16C	Related Party Allocation - Bridgemark		265
		$	53,017

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

	Description		
28A	Dues Reimbursement	$	10
28B	Recovery of Bad Debt		1,075
28C	Gain/Loss on Sale of Truck		100
28D	Miscellaneous Income		16
28E	PAC Reimbursement		212
		$	1,413