

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0050757

Facility Name: Richland Care and Rehab

Address: 410 East Mack Street Olney 62450
Number City Zip Code

County: Richland

Telephone Number: (618) 395-7421 Fax # (618) 395-8210

HFS ID Number:

Date of Initial License for Current Owners: 4/30/1998

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/11 to 12/31/11
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	
Paid Preparer	(Title)	Chief Financial Officer	
	(Signed)	See Accountant's Compilation Report	(Date)
	(Print Name and Title)	Cindy A. Tefsteller	
	(Firm Name & Address)	C.J. Schlosser & Company, L.L.C. 233 East Center Drive, Alton, IL 62002	
	(Telephone)	(618) 465-7717	Fax # (618) 465-7710
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Richland Care and Rehab

0050757 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 <u>N/A</u>					
	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>118</u>	Skilled (SNF)	<u>118</u>	<u>43,070</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	<u>7</u>

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,581</u>	<u>2,395</u>	<u>2,208</u>	<u>26,184</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>21,581</u>	<u>2,395</u>	<u>2,208</u>	<u>26,184</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.79%

SEE ACCOUNTANTS' COMPILATION REPORT

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 04/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/10 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 118 and days of care provided 2,035

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	145,135	16,557	4,994	166,686		166,686		166,686			1
2	Food Purchase		154,255		154,255		154,255	(70)	154,185			2
3	Housekeeping	82,250	22,612		104,862		104,862		104,862			3
4	Laundry	47,125	15,261		62,386		62,386		62,386			4
5	Heat and Other Utilities			100,351	100,351		100,351	(10,198)	90,153			5
6	Maintenance	38,604	5,536	39,081	83,221		83,221		83,221			6
7	Other (specify):*											7
8	TOTAL General Services	313,114	214,221	144,426	671,761		671,761	(10,268)	661,493			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,022,815	78,812	5,443	1,107,070		1,107,070	13,484	1,120,554			10
10a	Therapy		6,393	21	6,414		6,414		6,414			10a
11	Activities	46,064	6,345	6,146	58,555		58,555	(1,224)	57,331			11
12	Social Services	19,929	136	2,460	22,525		22,525		22,525			12
13	CNA Training											13
14	Program Transportation			6,810	6,810		6,810		6,810			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,088,808	91,686	32,880	1,213,374		1,213,374	12,260	1,225,634			16
	C. General Administration											
17	Administrative	73,033		171,200	244,233		244,233	(137,834)	106,399			17
18	Directors Fees											18
19	Professional Services			13,913	13,913		13,913	7,910	21,823			19
20	Dues, Fees, Subscriptions & Promotions			29,457	29,457		29,457	(15,426)	14,031			20
21	Clerical & General Office Expenses	53,131	13,401	42,183	108,715		108,715	132,270	240,985			21
22	Employee Benefits & Payroll Taxes			294,235	294,235		294,235	25,701	319,936			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,522	3,522		3,522	475	3,997			24
25	Other Admin. Staff Transportation			12,567	12,567		12,567	11,518	24,085			25
26	Insurance-Prop.Liab.Malpractice			53,498	53,498		53,498	931	54,429			26
27	Other (specify):*											27
28	TOTAL General Administration	126,164	13,401	620,575	760,140		760,140	25,545	785,685			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,528,086	319,308	797,881	2,645,275		2,645,275	27,537	2,672,812			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,118	8,118		8,118	4,142	12,260			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,844	60,844		60,844	(17)	60,827			32
33	Real Estate Taxes			59,110	59,110		59,110	44	59,154			33
34	Rent-Facility & Grounds			612,714	612,714		612,714	8,692	621,406			34
35	Rent-Equipment & Vehicles			12,670	12,670		12,670	260	12,930			35
36	Other (specify):*											36
37	TOTAL Ownership			753,456	753,456		753,456	13,121	766,577			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,912	639,947	734,859		734,859		734,859			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		94,912	704,552	799,464		799,464		799,464			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,528,086	414,220	2,255,889	4,198,195		4,198,195	40,658	4,238,853			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,224)	11		4
5	Telephone, TV & Radio in Resident Rooms	(10,532)	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	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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	(475)	20		17
18	Fines and Penalties	(12,500)	21		18
19	Entertainment	(1,985)	21		19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(150)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,231)	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	(4,577)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,811)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	85,469	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 85,469		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 40,658		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	\$ (1,707)	20	1
2	Eliminate Lobbying & PAC Dues	(2,870)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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	(4,577)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(70)	0	0	0	0	0	0	0	0	0	0	(70)	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	(10,532)	334	0	0	0	0	0	0	0	0	0	(10,198)	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	(10,602)	334	0	0	0	0	0	0	0	0	0	(10,268)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	13,484	0	0	0	0	0	0	0	0	0	13,484	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,224)	0	0	0	0	0	0	0	0	0	0	(1,224)	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	(1,224)	13,484	0	0	0	0	0	0	0	0	0	12,260	16
	C. General Administration													
17	Administrative	0	(137,834)	0	0	0	0	0	0	0	0	0	(137,834)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(150)	8,060	0	0	0	0	0	0	0	0	0	7,910	19
20	Fees, Subscriptions & Promotions	(18,283)	2,857	0	0	0	0	0	0	0	0	0	(15,426)	20
21	Clerical & General Office Expenses	(14,535)	146,805	0	0	0	0	0	0	0	0	0	132,270	21
22	Employee Benefits & Payroll Taxes	0	25,701	0	0	0	0	0	0	0	0	0	25,701	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	475	0	0	0	0	0	0	0	0	0	475	24
25	Other Admin. Staff Transportation	0	11,518	0	0	0	0	0	0	0	0	0	11,518	25
26	Insurance-Prop.Liab.Malpractice	0	931	0	0	0	0	0	0	0	0	0	931	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(32,968)	58,513	0	0	0	0	0	0	0	0	0	25,545	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,794)	72,331	0	0	0	0	0	0	0	0	0	27,537	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	4,142	0	0	0	0	0	0	0	0	0	4,142	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17)	0	0	0	0	0	0	0	0	0	0	(17)	32
33	Real Estate Taxes	0	44	0	0	0	0	0	0	0	0	0	44	33
34	Rent-Facility & Grounds	0	8,692	0	0	0	0	0	0	0	0	0	8,692	34
35	Rent-Equipment & Vehicles	0	0	260	0	0	0	0	0	0	0	0	260	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17)	12,878	260	0	0	0	0	0	0	0	0	13,121	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)	(44,811)	85,209	260	0	0	0	0	0	0	0	0	40,658	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint. Ser
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical Supply	St. Louis, MO	Medical Supplies
		Helia Healthcare of Energy	Energy, IL			
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

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%	\$ 334	\$ 334	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	13,484	13,484	2
3	V	17	Administrative	171,200	Bridgemark Healthcare, LLC	100.00%	33,366	(137,834)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	8,060	8,060	4
5	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	2,857	2,857	5
6	V	21	Clerical & General Expenses		Bridgemark Healthcare, LLC	100.00%	146,805	146,805	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	25,701	25,701	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	475	475	8
9	V	25	Other Admin Transportation		Bridgemark Healthcare, LLC	100.00%	11,518	11,518	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	931	931	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,142	4,142	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	44	44	12
13	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	8,692	8,692	13
14	Total			\$ 171,200			\$ 256,409	\$ * 85,209	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 260	\$ 260	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			\$			\$ 260	\$ * 260	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3			Helia Healthcare of Rolla	Rolla, MO				3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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	341,634	4	8.90	Distribution	\$ 33,366	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	\$ 33,366		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 Richland Care and Rehab # 0050757 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	294,279	12	\$ 3,751	\$	26,184	\$ 334	1
2	10	Nursing & Med	Resident Days	294,279	12	151,540	151,540	26,184	13,484	2
3	17	Owners Compensation	Resident Days	294,279	12	375,000		26,184	33,366	3
4	19	Professional Services	Resident Days	294,279	12	90,588		26,184	8,060	4
5	20	Dues & Subscriptions	Resident Days	294,279	12	32,105		26,184	2,857	5
6	21	Salaries - Other	Resident Days	294,279	12	1,135,681	1,135,681	26,184	101,049	6
7	21	Clerical & Office Supplies	Resident Days	294,279	12	514,247		26,184	45,756	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	294,279	12	288,855		26,184	25,701	8
9	24	Travel & Seminar	Resident Days	294,279	12	5,335		26,184	475	9
10	25	Other Admin Transp	Resident Days	294,279	12	129,453		26,184	11,518	10
11	26	Insurance	Resident Days	294,279	12	10,464		26,184	931	11
12	30	Depreciation	Resident Days	294,279	12	46,555		26,184	4,142	12
13	33	Real Estate Taxes	Resident Days	294,279	12	492		26,184	44	13
14	34	Building Rent	Resident Days	294,279	12	94,784		26,184	8,434	14
15	34	Rental - Storage Unit	Resident Days	294,279	12	2,905		26,184	258	15
16	35	Equipment Rental	Resident Days	294,279	12	2,920		26,184	260	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,884,675	\$ 1,287,221		\$ 256,669	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	60,844	6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 60,844	9
	B. Non-Facility Related*											
10	Interest Income		X								(17)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (17)	14
15	TOTALS (line 9+line14)						\$				\$ 60,827	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	59,110 2
3. Under or (over) accrual (line 2 minus line 1).				\$	59,110 3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	59,110 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	47,925	8	
		2007	47,925	9	
		2008	53,404	10	
		2009	57,388	11	
		2010	59,031	12	
59,110 Line 7					
44 Bridgemark Healthcare Allocation					
59,154 Total Schedule V, Line 33					

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Richland Care and Rehab COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0050757

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 2010 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 2010.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>06-27-450-002</u>	<u>Plat/Block/Lot PT SW SE SE</u>	\$ <u>59,031.30</u>	\$ <u>59,031.30</u>
2.	<u></u>	<u>Unplatted 55</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>59,031.30</u></u>	\$ <u><u>59,031.30</u></u>

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,034

B. General Construction Type: Exterior Brick Frame Steel/Concrete 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	Section N/A			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	20,000 Watt Generator			2010	8,067	1,613	5	1,613		3,092	9
10	Upgrade Existing Fire Alarm System			2010	16,191	1,619	10	1,619		2,968	10
11	Fire Alarm Panel & Fire Doors			2011	20,209	1,095	10	1,095		1,095	11
12	A/C System Improvements & New A/C Units			2011	9,134	659	15	659		659	12
13											13
14											14
15											15
16											16
17	Related Party Allocation - Bridgemark										17
18	New Office Build-Out			2011	12,084		20	289	289	289	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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 16,270	\$ 1,779	\$ 4,277	\$ 2,498	3-15	\$ 6,153	71
72	Current Year Purchases	26,085	501	1,399	898	3-15	1,399	72
73	Fully Depreciated Assets	50					50	73
74								74
75	TOTALS	\$ 42,405	\$ 2,280	\$ 5,676	\$ 3,396		\$ 7,602	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Ford E-450	2010	\$ 3,407	\$ 852	\$ 852	\$	4	\$ 1,633	76
77	Related Party Allocation - Bridgemark			1,182		457	457	4	764	77
78										78
79										79
80	TOTALS			\$ 4,589	\$ 852	\$ 1,309	\$ 457		\$ 2,397	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)	\$ 112,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,260	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,142	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,102	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	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: CR Aviv, 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:		118		\$ 611,514			3
4	Additions							4
5	Storage Rental				1,200			5
6	Related Party Allocation - Bridgemark				8,692			6
7	TOTAL		118		\$ 621,406			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
- N/A
- N/A

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: \$ 12,930
- 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

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. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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

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, 2	hrs	\$		\$	451		\$	451	1	
2	Licensed Speech and Language Development Therapist	10a, 2	hrs				465			465	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10a, 2	hrs				5,477			5,477	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39, 2	# of prescripts				60,018			60,018	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): <u>Wound Care, Oxygen</u>	39, 2					34,894			34,894	12	
13	Physical, Occupational & Speech Ther Other (specify): <u>Lab, X-Ray, Other</u>	39, 3					639,947			639,947	13	
14	TOTAL			\$		\$	639,947	\$	101,305	\$	741,252	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

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,700	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 71,467)	744,740		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	23,932		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,519		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	2,855		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 776,746	\$	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	46,849		15
16	Equipment, at Historical Cost	36,503		16
17	Accumulated Depreciation (book methods)	(12,574)		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)	\$ 70,778	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 847,524	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 634,223	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,763		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,565		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Bridgemark Healthcare	1,523,679		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,244,230	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,244,230	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,396,706)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 847,524	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (569,846)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (569,846)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(826,860)	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)	\$ (826,860)	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)	\$ (1,396,706)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,988,590	1
2	Discounts and Allowances for all Levels	(51,200)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,937,390	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	432,255	6
7	Oxygen	16	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 432,271	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	1,224	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)	\$ 1,224	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	433	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 433	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,371,335	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	671,761	31
32	Health Care	1,213,374	32
33	General Administration	760,140	33
	B. Capital Expense		
34	Ownership	753,456	34
	C. Ancillary Expense		
35	Special Cost Centers	734,859	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,198,195	40
41	Income before Income Taxes (line 30 minus line 40)**	(826,860)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (826,860)	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.

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	1,240	1,240	\$ 36,478	\$ 29.42	1
2	Assistant Director of Nursing	1,408	1,489	24,076	16.17	2
3	Registered Nurses	5,712	5,888	113,927	19.35	3
4	Licensed Practical Nurses	20,137	21,116	354,735	16.80	4
5	CNAs & Orderlies	47,996	50,386	452,709	8.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,807	2,077	22,355	10.76	8
9	Activity Director					9
10	Activity Assistants	4,452	4,733	46,064	9.73	10
11	Social Service Workers	1,178	1,178	19,929	16.92	11
12	Dietician					12
13	Food Service Supervisor	2,044	2,160	30,554	14.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,528	13,196	114,581	8.68	15
16	Dishwashers					16
17	Maintenance Workers	3,553	3,792	38,604	10.18	17
18	Housekeepers	8,087	8,537	82,250	9.63	18
19	Laundry	5,530	5,745	47,125	8.20	19
20	Administrator	2,104	2,181	73,033	33.49	20
21	Assistant Administrator					21
22	Other Administrative	557	557	9,461	16.99	22
23	Office Manager	2,135	2,286	43,670	19.10	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,610	1,921	18,535	9.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,078	128,482	\$ 1,528,086 *	\$ 11.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 4,994	1, 3	35
36	Medical Director		12,000	9, 3	36
37	Medical Records Consultant		1,963	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,480	10, 3	39
40	Physical Therapy Consultant		21	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		6,146	11, 3	44
45	Social Service Consultant		2,460	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,064		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			
Name	Function	% Ownership	Amount
Stacy Blue	Administrator	0	\$ 46,011
Pamela Lucas	Administrator	0	16,067
Paula McKnight	Administrator	0	10,955
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,033
B. Administrative - Other			
Description			Amount
Bridgemark Healthcare LLC - Management Fees		\$	171,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 171,200
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company, LLC	Accounting Services	\$	5,325
Ceridian	Payroll Processing		8,438
Kramer & Frank	Collections		150
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 13,913
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	74,679
Unemployment Compensation Insurance			8,750
FICA Taxes			179,853
Employee Health Insurance			27,515
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401(k) Match			2,333
Employee Benefits			35
Uniforms			1,070
Related Party Allocation - Bridgemark			25,701
TOTAL (agree to Schedule V, line 22, col.8)			\$ 319,936
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
Schedule N/A		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			3,619
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			1,695
Late Fees			768
Dues & Subscriptions			4,629
Misc. Fees & Licenses			463
Advertising			13,231
Related Party Allocation - Bridgemark			2,857
Less: Public Relations Expense		(	
Non-allowable advertising			(13,231)
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 14,031
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			634
Seminar Expense			2,888
Related Party Allocation - Bridgemark			475
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	3,997

*** 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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

(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?
If YES, give association name and amount.

Yes
IHCA \$4,210

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

Yes
Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

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

Yes
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.

\$ 10,569 Line 10

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

Yes

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X

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

\$ 64,605

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

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

N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
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.

No

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?
Indicate the amount.

\$ None
No \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A
N/A
N/A
N/A
N/A
No
\$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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?
Attach invoices and a summary of services for all architect and appraisal fees

N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Olney d/b/a Richland Care & Rehab
Attachment to Schedule XII B
Equipment Rentals
12/31/2011

Description		
16A	Nursing Equipment Rental	\$ 11,656
16B	Copier Lease	66
16C	Dietary Equipment Rental	948
16D	Related Party Allocation - Bridgemark	260
		<u>\$ 12,930</u>

Richland Rehab and Care Center
Attachment to Schedule XX G.
Seminar Detailed Description
12/31/2011

Name of Employee Attending	Job Title	Date	Seminar Title	Seminar Sponsor	Seminar Cost	Travel Cost
Stacy Blue,Christy Richards, Brandy Miller, Tracey Kocker		1/21/11	Train the trainer	Alzheimer's Association	\$ 360	\$ -
Sue Crump	Alz Direct	2/22/11	Krump train the trainer	Alzheimer's Association	\$ 85	
Sue Crump		3/3/11	CEU's for train the trainer	Alzheimer's Association	\$ 10	
This is activity membership		3/16/11	activity training	SIATA	\$ 70	
Tracey Kocher		4/12/11	Dementia seminar	Heartland Human Services -	\$ 50	
Scott Mitchell	Alz Direct	5/2/11	rain the trainer seminar	Alzheimer's Association	\$ 85	
Christy Richards, Brandy Miller, Peggy Lister		6/20/11	3 MDS Training	Illinois Health Care Associati -	\$ 450	
Pam Lucas	Administrator	7/6/11	IL Nur Home Admin Assoc	INHAA	\$ 95	
Mary Kasting	Act Dir	7/19/11	Act Director Course	Outcome Services of Illinois, -	\$ 405	
Jodi Roderick	Alz Direct	8/12/11	Dementai Care Training	Alzheimer's Association	\$ 80	
Donna Horn, Jenifer Workman, Nan Dunn, Christy Richards		8/31/11	IHCA Convention	Illinois Health Care Association	\$ 795	
Nan Dunn	Dietary Man	10/12/11	dietary training	IL Dietary Mangers Association -	\$ 75	
Donna Horn	DON	11/30/11		Il Healthcare Asoc	\$ 150	
Lodging for employees in Belleville						\$ 383
Miscellaneous					\$ 178	\$ 251
Related Party Allocation - Bridgemark					\$ 475	
					<u>\$ 3,363</u>	<u>\$ 634</u>
						\$ 3,997