

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

<p>I. IDPH License ID Number: <u>0048827</u></p> <p>Facility Name: <u>Helia HC of Belleville</u></p> <p>Address: <u>40 North 64th St</u> <u>Belleville</u> <u>62223</u> <small>Number City Zip Code</small></p> <p>County: <u>St Clair</u></p> <p>Telephone Number: <u>(618) 397-8400</u> Fax # <u>(618) 397-8470</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/1/1996</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618)465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u>							
Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Belleville

0048827 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,652</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>122</u>	TOTALS	<u>122</u>	<u>44,652</u>	7

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>19,448</u>	<u>1,017</u>	<u>10,206</u>	<u>30,671</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,448</u>	<u>1,017</u>	<u>10,206</u>	<u>30,671</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.69%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/01/07

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 122 and days of care provided 3,126

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	165,047	24,818	12,011	201,876		201,876		201,876		1
2	Food Purchase		151,089		151,089		151,089	(25)	151,064		2
3	Housekeeping	97,220	33,907		131,127		131,127		131,127		3
4	Laundry	60,482	26,108		86,590		86,590		86,590		4
5	Heat and Other Utilities			128,196	128,196		128,196	399	128,595		5
6	Maintenance	63,875	13,289	119,386	196,550		196,550		196,550		6
7	Other (specify):*										7
8	TOTAL General Services	386,624	249,211	259,593	895,428		895,428	374	895,802		8
	B. Health Care and Programs										
9	Medical Director			34,800	34,800		34,800		34,800		9
10	Nursing and Medical Records	1,750,190	142,037	4,099	1,896,326		1,896,326	9,199	1,905,525		10
10a	Therapy	589,026	104,430		693,456		693,456		693,456		10a
11	Activities	71,101	11,114	7,563	89,778		89,778	(1,413)	88,365		11
12	Social Services	51,792	91	2,858	54,741		54,741		54,741		12
13	CNA Training										13
14	Program Transportation			13,781	13,781		13,781		13,781		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,462,109	257,672	63,101	2,782,882		2,782,882	7,786	2,790,668		16
	C. General Administration										
17	Administrative	64,433		395,700	460,133		460,133	(358,456)	101,677		17
18	Directors Fees										18
19	Professional Services			22,061	22,061		22,061	13,147	35,208		19
20	Dues, Fees, Subscriptions & Promotions			59,965	59,965		59,965	(43,933)	16,032		20
21	Clerical & General Office Expenses	83,187	24,422	58,943	166,552		166,552	199,635	366,187		21
22	Employee Benefits & Payroll Taxes			571,565	571,565		571,565	35,292	606,857		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,718	1,718		1,718	3,862	5,580		24
25	Other Admin. Staff Transportation			3,960	3,960		3,960	6,601	10,561		25
26	Insurance-Prop.Liab.Malpractice			15,251	15,251		15,251	1,460	16,711		26
27	Other (specify):*										27
28	TOTAL General Administration	147,620	24,422	1,129,163	1,301,205		1,301,205	(142,392)	1,158,813		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,996,353	531,305	1,451,857	4,979,515		4,979,515	(134,232)	4,845,283		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 HC of Belleville

#0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			28,670	28,670		28,670	11,018	39,688			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,911	4,911		4,911	370	5,281			32
33	Real Estate Taxes			66,510	66,510		66,510	125	66,635			33
34	Rent-Facility & Grounds			609,294	609,294		609,294	13,908	623,202			34
35	Rent-Equipment & Vehicles			269,337	269,337		269,337	(94,523)	174,814			35
36	Other (specify):*											36
37	TOTAL Ownership			978,722	978,722		978,722	(69,102)	909,620			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		442,841	546,455	989,296		989,296		989,296			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			326,053	326,053		326,053		326,053			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		442,841	872,508	1,315,349		1,315,349		1,315,349			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,996,353	974,146	3,303,087	7,273,586		7,273,586	(203,334)	7,070,252			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 HC of Belleville

0048827

Report Period Beginning: 01/01/12

Ending: 12/31/12

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,413)	11		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,405	30		9
10	Interest and Other Investment Income	(3,753)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	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	(550)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,104)	21		19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(31,541)	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	(13,222)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (53,453)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(149,881)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (149,881)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (203,334)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia HC of Belleville

ID# 0048827

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts & Flowers	\$ (10,453)	20	1
2	Eliminate Lobbying & PAC Dues	(1,804)	20	2
3	Offset Medical Record Copy Revenue	(965)	10	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	(13,222)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia HC of Belleville# 0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	(25)	0	0	0	0	0	0	0	0	0	0	(25)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	399	0	0	0	0	0	0	0	0	0	399	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	(25)	399	0	0	0	0	0	0	0	0	0	374	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	(965)	10,164	0	0	0	0	0	0	0	0	0	9,199	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,413)	0	0	0	0	0	0	0	0	0	0	(1,413)	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	(2,378)	10,164	0	0	0	0	0	0	0	0	0	7,786	16
	C. General Administration													
17	Administrative	0	(358,456)	0	0	0	0	0	0	0	0	0	(358,456)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,147	0	0	0	0	0	0	0	0	0	13,147	19
20	Fees, Subscriptions & Promotions	(44,348)	415	0	0	0	0	0	0	0	0	0	(43,933)	20
21	Clerical & General Office Expenses	(4,354)	203,745	244	0	0	0	0	0	0	0	0	199,635	21
22	Employee Benefits & Payroll Taxes	0	35,292	0	0	0	0	0	0	0	0	0	35,292	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,862	0	0	0	0	0	0	0	0	0	3,862	24
25	Other Admin. Staff Transportation	0	6,601	0	0	0	0	0	0	0	0	0	6,601	25
26	Insurance-Prop.Liab.Malpractice	0	1,460	0	0	0	0	0	0	0	0	0	1,460	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(48,702)	(93,934)	244	0	0	0	0	0	0	0	0	(142,392)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,105)	(83,371)	244	0	0	0	0	0	0	0	0	(134,232)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia HC of Belleville# 0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	1,405	5,203	4,410	0	0	0	0	0	0	0	0	11,018	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,753)	3,616	507	0	0	0	0	0	0	0	0	370	32
33	Real Estate Taxes	0	125	0	0	0	0	0	0	0	0	0	125	33
34	Rent-Facility & Grounds	0	0	13,908	0	0	0	0	0	0	0	0	13,908	34
35	Rent-Equipment & Vehicles	0	0	(94,523)	0	0	0	0	0	0	0	0	(94,523)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,348)	8,944	(75,698)	0	0	0	0	0	0	0	0	(69,102)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(53,453)	(74,427)	(75,454)	0	0	0	0	0	0	0	0	(203,334)	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 Benton	Benton, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Carbondale	Carbondale, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical Supply	St. Louis, MO	Medical Supplies
		Helia Healthcare of Olney	Olney, 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%	\$ 399	\$	399	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	10,164		10,164	2
3	V	17 Management Fees	395,700	Bridgemark Healthcare, LLC	100.00%	37,244		(358,456)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	13,147		13,147	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	415		415	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	203,745		203,745	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	35,292		35,292	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,862		3,862	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	6,601		6,601	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,460		1,460	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	5,203		5,203	11
12	V	32 Interest		Bridgemark Healthcare, LLC	100.00%	3,616		3,616	12
13	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	125		125	13
14	Total		\$ 395,700			\$ 321,273	\$ *	(74,427)	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. 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	34 Rent - Facility & Grounds	\$	Bridgemark Healthcare, LLC	100.00%	\$ 11,912	\$ 11,912
16	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	333	333
17	V						
18	V						
19	V	21 Clerical & Office Supplies		Bridgemark Medical Supply	100.00%	244	244
20	V	30 Depreciation		Bridgemark Medical Supply	100.00%	4,410	4,410
21	V	32 Interest		Bridgemark Medical Supply	100.00%	507	507
22	V	34 Building Rent		Bridgemark Medical Supply	100.00%	1,996	1,996
23	V	35 Equipment Rental	94,856	Bridgemark Medical Supply	100.00%		(94,856)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 94,856			\$ 19,402	\$ * (75,454)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Belleville

0048827

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

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								1
2			Helia Southbelt Healthcare	Belleville, IL				2
3			Hillside Rehab & Care Center	Yorkville, IL				3
4			Helia Healthcare of Rolla	Rolla, MO				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

Facility Name & ID Number Helia HC of Belleville # 0048827 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	299,381	5.53	11.06	Distribution	\$ 37,244	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	\$ 37,244		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 HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	277,215	11	\$ 3,605	\$ 30,671	\$ 399	1
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	30,671	10,164	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625	30,671	37,244	3
4	19	Professional Fees	Resident Days	277,215	11	118,827	30,671	13,147	4
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754	30,671	415	5
6	21	Clerical & Office Supplies	Resident Days	277,215	11	1,841,520	30,671	203,745	6
7	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977	30,671	35,292	7
8	24	Seminars	Resident Days	277,215	11	34,902	30,671	3,862	8
9	25	Admin Staff Travel	Resident Days	277,215	11	59,659	30,671	6,601	9
10	26	Insurance	Resident Days	277,215	11	13,196	30,671	1,460	10
11	30	Depreciation	Resident Days	277,215	11	47,028	30,671	5,203	11
12	32	Interest	Resident Days	277,215	11	32,681	30,671	3,616	12
13	33	Real Estate Taxes	Resident Days	277,215	11	1,133	30,671	125	13
14	34	Building Rent	Resident Days	277,215	11	103,521	30,671	11,454	14
15	34	Rental-Storage Unit	Resident Days	277,215	11	4,139	30,671	458	15
16	35	Equipment Rental	Resident Days	277,215	11	3,007	30,671	333	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,014,441	\$ 1,437,534		\$ 333,518	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Bridgemark Medical Supply
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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	21	Clerical & Office Supplies	Revenue	336,537	5	\$ 865	\$ 94,856	\$ 244	1
2	30	Depreciation	Revenue	336,537	5	15,646	94,856	4,410	2
3	32	Interest	Revenue	336,537	5	1,800	94,856	507	3
4	34	Building Rent	Revenue	336,537	5	7,080	94,856	1,996	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	TOTALS					\$ 25,391	\$	\$ 7,157	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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	4,911	6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$ 4,911	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(3,753)	10
11												11
12	Related Party Allocation - Bridgemark Healthcare										3,616	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (137)	14
15	TOTALS (line 9+line14)						\$	\$			\$ 4,774	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.)

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 2011 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.)		\$	66,510		2
3. Under or (over) accrual (line 2 minus line 1).		\$	66,510		3
4. Real Estate Tax accrual used for 2012 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.		\$	66,510		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<u>76,998</u>	8		
	2008	<u>80,745</u>	9		
	2009	<u>73,277</u>	10		
	2010	<u>64,585</u>	11		
	2011	<u>64,572</u>	12		
66,510 Line 7, Real Estate Tax portion of Lease Payment					
125 Bridgemark Healthcare Allocation					
66,635 Total Schedule V, Line 33					
				FOR BHF USE ONLY	
				13 FROM R. E. TAX STATEMENT FOR 2011 \$	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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia HC of Belleville COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048827

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 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-12.0-213-024</u>	<u>Penns 2nd Bub Lot/Sec-61 PT LTS</u>	\$ <u>64,572.46</u>	\$ <u>64,572.46</u>
2. _____	<u>61, 62 & 64</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>64,572.46</u></u>	\$ <u><u>64,572.46</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 HC of Belleville

0048827 Report Period Beginning:

01/01/12 Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Plasterers	2007		6,731	337	20	337		2,019	9
10		A/C Units	2007		1,072		5			1,072	10
11		Water Heater	2007		2,945		5			2,945	11
12		Air Units	2007		1,215	121	10	121		729	12
13		Supplies for Sign	2007		1,060	106	10	106		636	13
14		100 Gal. Water Heater	2008		8,183	818	10	818		3,818	14
15		Vanities	2008		810	81	10	81		405	15
16		Windows	2008		1,065	53	20	53		231	16
17		Sprinklers	2008		7,898	527	15	527		2,238	17
18		Asphalt for Rear of Building	2008		2,085	261	8	261		1,064	18
19		New Water Pump	2008		1,439	144	10	144		588	19
20		New Nurse's Station & Renovation of front entrance & hallways	2009		35,615	2,374	15	2,374		8,030	20
21		Asphalt for Front of Building	2009		1,295	162	8	162		553	21
22		Cabinets	2009		3,965	264	15	264		881	22
23		Carpet	2009		9,553	1,911	5	1,911		6,368	23
24		14 Doors	2009		4,382	292	15	292		925	24
25		Water Heater	2009		4,415	442	10	442		1,398	25
26		Cable Installation	2009		8,031	803	10	803		2,476	26
27		Wing Remodel-carpet,hand rails,paint,nurses station,plumbing,door:	2010		56,248	2,812	20	2,812		6,328	27
28		Rooftop Heater & Compressor	2010		6,782	452	15	452		1,243	28
29		Cabinets for utility	2010		1,023	68	15	68		170	29
30		Tile & Carpet	2010		4,793	959	5	959		2,317	30
31		Coutertops	2010		1,352	90	10	90		218	31
32		Facility Signage	2010		3,292	329	10	329		713	32
33		Kick Plates for Hallway	2010		431	86	5	86		187	33
34		A/C Units	2011		6,876	688	10	688		1,319	34
35		Shower Room-Flooring, electric, shower heads, fixtures, paint	2011		9,427	628	15	628		681	35
36		A/C Units	2011		6,675	1,335	5	1,335		2,129	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 HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2 Add'l cameras for security system	2012	\$ 594	\$ 79	5	\$ 79	\$	\$ 79	37
38	New Amp Meter	2012	595	40	10	40		40	38
39	Replaced security system keypad	2012	717	42	10	42		42	39
40	HVAC System	2012	6,755	225	15	225		225	40
41	Entrance Door	2012	2,397	27	15	27		27	41
42	PTAC Units	2012	2,169	73	10	73		73	42
43	Water Heater Booster	2012	1,448	36	10	36		36	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55	Related Party Allocation - Bridgemark Healthcare LLC								55
56	New Office Build-Out	2011	15,027		20	796	796	1,157	56
57	Conference Rm Chair Rail & Paint	2012	170		5	11	11	11	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)		\$ 228,530	\$ 16,665		\$ 17,472	\$ 807	\$ 53,371	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 155,506	\$ 10,129	\$ 19,607	\$ 9,478	5-10	\$ 64,001	71
72	Current Year Purchases	7,728	876	1,241	365	5-10	1,241	72
73	Fully Depreciated Assets	217					217	73
74								74
75	TOTALS	\$ 163,451	\$ 11,005	\$ 20,848	\$ 9,843		\$ 65,459	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	Related Party Allocation-Bridgemark			\$ 1,470	\$	\$ 368	\$ 368	4	\$ 1,317	76
77	Facility	2002 Ford E-450	2010	4,000	1,000	1,000		4	2,500	77
78										78
79										79
80	TOTALS			\$ 5,470	\$ 1,000	\$ 1,368	\$ 368		\$ 3,817	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)	\$ 397,451	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,670	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,688	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,018	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 122,647	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Belleville Illinois, L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>122</u>		\$ <u>609,294</u>			3
4	Additions							4
5	<u>Related Party Allocation-Bridgemark</u>				<u>11,912</u>			5
6								6
7	TOTAL		122		\$ 621,206			7

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

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: \$ 174,814

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 HC of Belleville # 0048827 Report Period Beginning: 01/01/12 Ending: 12/31/12
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a,2	hrs	\$		\$	\$	124		\$	124	1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a,2	hrs					5,029			5,029	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39,2	# of prescrpts					204,641			204,641	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3					546,455				546,455	12
13	Other (specify): <u>Wound, Enterals</u>	39,2						238,200			238,200	13
14	TOTAL			\$		\$	546,455	\$	447,994	\$	994,449	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 HC of Belleville# 0048827Report Period Beginning: 01/01/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>112,119</u>)	<u>2,732,432</u>		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	<u>22,264</u>		7
8	Accounts Receivable (owners or related parties)	<u>1,539,342</u>		8
9	Other(specify): <u>Deposits</u>	<u>483</u>		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ <u>4,294,521</u>	\$	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	<u>207,042</u>		15
16	Equipment, at Historical Cost	<u>87,726</u>		16
17	Accumulated Depreciation (book methods)	<u>(81,742)</u>		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)	\$ <u>213,026</u>	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ <u>4,507,547</u>	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ <u>979,896</u>	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	<u>272,519</u>		30
31	Accrued Taxes Payable (excluding real estate taxes)	<u>15,709</u>		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ <u>1,268,124</u>	\$	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)	\$ <u>1,268,124</u>	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ <u>3,239,423</u>	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ <u>4,507,547</u>	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,069,973	1
2	Restatements (describe):		2
3			3
4	Prior Year Depreciation Adjustment	(2,223)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,067,750	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	171,673	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)	\$ 171,673	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)	\$ 3,239,423	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,224,701	1
2	Discounts and Allowances for all Levels	(117,800)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,106,901	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	202,665	6
7	Oxygen	129,151	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 331,816	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	1,413	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)	\$ 1,413	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,753	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,753	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	965	28
28a	Miscellaneous	411	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,376	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,445,259	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	895,428	31
32	Health Care	2,782,882	32
33	General Administration	1,301,205	33
B. Capital Expense			
34	Ownership	978,722	34
C. Ancillary Expense			
35	Special Cost Centers	989,296	35
36	Provider Participation Fee	326,053	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,273,586	40
41	Income before Income Taxes (line 30 minus line 40)**	171,673	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 171,673	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Filed Yet** 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	1,288	1,396	\$ 37,298	\$ 26.72	1
2	Assistant Director of Nursing	2,007	2,142	70,271	32.81	2
3	Registered Nurses	8,113	8,426	236,914	28.12	3
4	Licensed Practical Nurses	27,602	30,679	676,524	22.05	4
5	CNAs & Orderlies	54,482	59,687	689,836	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,251	6,119	97,505	15.93	8
9	Activity Director					9
10	Activity Assistants	4,719	5,417	71,101	13.13	10
11	Social Service Workers	1,830	2,074	51,792	24.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,744	15,976	165,047	10.33	15
16	Dishwashers					16
17	Maintenance Workers	2,131	2,302	63,875	27.75	17
18	Housekeepers	9,237	10,196	97,220	9.54	18
19	Laundry	6,005	6,590	60,482	9.18	19
20	Administrator	1,813	2,065	64,433	31.20	20
21	Assistant Administrator					21
22	Other Administrative	4,030	4,549	66,607	14.64	22
23	Office Manager	433	574	16,580	28.89	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	1,573	1,892	39,347	20.80	31
32	Other Health C: <u>Resp. Therapy</u>	19,036	20,488	491,521	23.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,294	180,572	\$ 2,996,353 *	\$ 16.59	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	\$ 12,011	1,3	35
36	Medical Director	34,800	9,3	36
37	Medical Records Consultant	3,187	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	712	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	7,563	11,3	44
45	Social Service Consultant	2,858	12,3	45
46	Other(specify) <u>Psych Consultant</u>	200	10,3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 61,331		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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

Facility Name & ID Number Helia HC of Belleville

0048827

Report Period Beginning:

01/01/12

Ending:

12/31/12

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$2,466
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 782 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 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. \$ 326,053
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? None 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? 57%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Belleville
Attachment to Schedule XII B
Equipment Rentals
12/31/2012

<u>Description</u>		
16A	Specialty Bed Rental	\$ 148,943
16B	Respiratory Equipment	24,845
16C	Dietary Equipment	200
16D	Copier Lease	493
16E	Related Party Allocation - Bridgemark	333
		<u>\$ 174,814</u>