FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0048587

Facility Name: Helia Southbelt HC

Address: 101 S Belt West (Number) | Belleville (City) | 62220 (Zip Code)

County: St Clair

Telephone Number: (618) 277-7700 **Fax #** (618) 355-4050

HFS ID Number:

Date of Initial License for Current Owners: 10/02/08

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. 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 Helia Southbelt HC # 0048587 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	156	Skilled (SNF)	156	57,096	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	156	TOTALS	156	57,096	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,349	8,646	11,982	46,977	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,349	8,646	11,982	46,977	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.28%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/2/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/2/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 156 and days of care provided 6,706

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/12 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 Southbelt HC # 0048587 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	256,076	22,892	13,355	292,323		292,323		292,323			1
2	Food Purchase		221,028		221,028		221,028	(201)	220,827			2
3	Housekeeping	165,076	43,213	140	208,429		208,429		208,429			3
4	Laundry	95,744	38,598		134,342		134,342		134,342			4
5	Heat and Other Utilities			122,330	122,330		122,330	(1,152)	121,178			5
6	Maintenance	61,171	17,993	67,395	146,559		146,559		146,559			6
7	Other (specify):*											7
8	**TOTAL General Services**	578,067	343,724	203,220	1,125,011		1,125,011	(1,353)	1,123,658			8
	B. Health Care and Programs											
9	Medical Director			7,950	7,950		7,950		7,950			9
10	Nursing and Medical Records	2,422,090	147,141		2,569,231		2,569,231	13,734	2,582,965			10
10a	Therapy		1,064		1,064		1,064		1,064			10a
11	Activities	85,782	17,437	8,751	111,970		111,970	(1,572)	110,398			11
12	Social Services	33,779		2,691	36,470		36,470		36,470			12
13	CNA Training											13
14	Program Transportation			10,860	10,860		10,860		10,860			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,541,651	165,642	30,252	2,737,545		2,737,545	12,162	2,749,707			16
	C. General Administration											
17	Administrative	75,647		420,200	495,847		495,847	(363,155)	132,692			17
18	Directors Fees											18
19	Professional Services			43,115	43,115	(16,407)	26,708	20,136	46,844			19
20	Dues, Fees, Subscriptions & Promotions			67,767	67,767		67,767	(45,904)	21,863			20
21	Clerical & General Office Expenses	162,737	20,961	61,667	245,365		245,365	300,237	545,602			21
22	Employee Benefits & Payroll Taxes			662,063	662,063		662,063	54,054	716,117			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,425	2,425		2,425	5,915	8,340			24
25	Other Admin. Staff Transportation			9,105	9,105		9,105	10,110	19,215			25
26	Insurance-Prop.Liab.Malpractice			23,477	23,477		23,477	2,236	25,713			26
27	Other (specify):*											27
28	**TOTAL General Administration**	238,384	20,961	1,289,819	1,549,164	(16,407)	1,532,757	(16,371)	1,516,386			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,358,102	530,327	1,523,291	5,411,720	(16,407)	5,395,313	(5,562)	5,389,751			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 Southbelt HC #0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,452	14,452		14,452	8,048	22,500			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,087	53,087		53,087	5,529	58,616			32
33	Real Estate Taxes			66,375	66,375	16,407	82,782	192	82,974			33
34	Rent-Facility & Grounds			772,685	772,685		772,685	18,244	790,929			34
35	Rent-Equipment & Vehicles			68,336	68,336		68,336	510	68,846			35
36	Other (specify):*											36
37	**TOTAL Ownership**			974,935	974,935	16,407	991,342	32,523	1,023,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		278,700	1,081,671	1,360,371		1,360,371		1,360,371			39
40	Barber and Beauty Shops	29,175			29,175		29,175		29,175			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			456,582	456,582		456,582		456,582			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	29,175	278,700	1,538,253	1,846,128		1,846,128		1,846,128			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,387,277	809,027	4,036,479	8,232,783		8,232,783	26,961	8,259,744			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 Southbelt HC # 0048587 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,572)	11		4
5	Telephone, TV & Radio in Resident Rooms	(1,763)	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	78	30		9
10	Interest and Other Investment Income	(9)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(201)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,200)	21		18
19	Entertainment	(3,034)	21		19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,594)	21		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(30,485)	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	(17,889)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,669)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	90,630	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 90,630		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 26,961		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

Helia Southbelt HC

ID# 0048587

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (13,748)	20	1
2	Eliminate Lobbying & PAC Dues	(2,307)	20	2
3	Offset Medical Records Income	(1,834)	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**	(17,889)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Southbelt HC **#** 0048587 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(201)	0	0	0	0	0	0	0	0	0	0	(201)	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	(1,763)	611	0	0	0	0	0	0	0	0	0	(1,152)	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**	(1,964)	611	0	0	0	0	0	0	0	0	0	(1,353)	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	(1,834)	15,568	0	0	0	0	0	0	0	0	0	13,734	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,572)	0	0	0	0	0	0	0	0	0	0	(1,572)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,406)	15,568	0	0	0	0	0	0	0	0	0	12,162	16
	C. General Administration													
17	Administrative	0	(363,155)	0	0	0	0	0	0	0	0	0	(363,155)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,136	0	0	0	0	0	0	0	0	0	20,136	19
20	Fees, Subscriptions & Promotions	(46,540)	636	0	0	0	0	0	0	0	0	0	(45,904)	20
21	Clerical & General Office Expenses	(11,828)	312,065	0	0	0	0	0	0	0	0	0	300,237	21
22	Employee Benefits & Payroll Taxes	0	54,054	0	0	0	0	0	0	0	0	0	54,054	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,915	0	0	0	0	0	0	0	0	0	5,915	24
25	Other Admin. Staff Transportation	0	10,110	0	0	0	0	0	0	0	0	0	10,110	25
26	Insurance-Prop.Liab.Malpractice	0	2,236	0	0	0	0	0	0	0	0	0	2,236	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(58,368)	41,997	0	0	0	0	0	0	0	0	0	(16,371)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,738)	58,176	0	0	0	0	0	0	0	0	0	(5,562)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Southbelt HC # 0048587 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 D. Ownership	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)	
30	Depreciation	78	7,970	0	0	0	0	0	0	0	0	0	8,048	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9)	5,538	0	0	0	0	0	0	0	0	0	5,529	32
33	Real Estate Taxes	0	192	0	0	0	0	0	0	0	0	0	192	33
34	Rent-Facility & Grounds	0	0	18,244	0	0	0	0	0	0	0	0	18,244	34
35	Rent-Equipment & Vehicles	0	0	510	0	0	0	0	0	0	0	0	510	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	69	13,700	18,754	0	0	0	0	0	0	0	0	32,523	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)	(63,669)	71,876	18,754	0	0	0	0	0	0	0	0	26,961	45

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.
		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 Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 611	$ 611	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	15,568	15,568	2
3	V	17	Administrative	420,200	Bridgemark Healthcare, LLC	100.00%	57,045	(363,155)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	20,136	20,136	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	636	636	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	312,065	312,065	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	54,054	54,054	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,915	5,915	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	10,110	10,110	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,236	2,236	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	7,970	7,970	11
12	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	5,538	5,538	12
13	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	192	192	13
14	Total			$ 420,200			$ 492,076	$ * 71,876	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent - Facility & Grounds	$	Bridgemark Healthcare, LLC	100.00%	$ 18,244	$ 18,244	15
16	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	510	510	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			$			$ 18,754	$ * 18,754	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 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			Frankfort Healthcare & Rehab Center	West Frankfort, 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 Southbelt HC # 0048587 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	279,580	8.47	16.95	Distribution	$ 57,045	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	$ 57,045		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 Southbelt HC # 0048587 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	277,215	11	$ 3,605	$	46,977	$ 611	1
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	46,977	15,568	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625		46,977	57,045	3
4	19	Professional Fees	Resident Days	277,215	11	118,827		46,977	20,136	4
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754		46,977	636	5
6	21	Salaries-Other	Resident Days	277,215	11	1,345,667	1,345,667	46,977	228,037	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853		46,977	84,028	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977		46,977	54,054	8
9	24	Seminars	Resident Days	277,215	11	34,902		46,977	5,915	9
10	25	Admin Staff Travel	Resident Days	277,215	11	59,659		46,977	10,110	10
11	26	Insurance	Resident Days	277,215	11	13,196		46,977	2,236	11
12	30	Depreciation	Resident Days	277,215	11	47,029		46,977	7,970	12
13	32	Interest	Resident Days	277,215	11	32,681		46,977	5,538	13
14	33	Real Estate Taxes	Resident Days	277,215	11	1,133		46,977	192	14
15	34	Building Rent	Resident Days	277,215	11	103,521		46,977	17,543	15
16	34	Rental-Storage Unit	Resident Days	277,215	11	4,139		46,977	701	16
17	35	Equipment Rental	Resident Days	277,215	11	3,007		46,977	510	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,014,442	$ 1,437,534		$ 510,830	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	53,087	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 53,087	9
	B. Non-Facility Related*											
10	Interest Income		X								(9)	10
11	Related Party Allocation - Bridgemark Healthcare										5,538	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 5,529	14
15	TOTALS (line 9+line14)						$	$			$ 58,616	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 109,897	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.)		$ (6,890)	2
3. Under or (over) accrual (line 2 minus line 1).		$ (116,787)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 183,162	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.)		$ 16,407	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.		$ 82,782	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	114,076	8
	2008	119,380	9
	2009	125,766	10
	2010	117,905	11
	2011	72,941	12

82,782 Line 7
192 Bridgemark Healthcare Allocation
82,974 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 Southbelt HC COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048587

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-28.0-403-066	LOT/SEC-58PT LT 58	$ 519.72	$ 519.72
2.	08-28.0-403-056	LOT/SEC-58PT LOTS 57 & 58	$ 6,927.36	$ 6,927.36
3.	08-28.0-403.004	LOT/SEC-4 PT LYG S OF RICH CRI	$	$
4.	08-28.0-403.003	LOT/SEC-3 PT LYG S OF RICH CRI	$ 51.66	$ 51.66
5.	08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CRI	$ 106.00	$ 106.00
6.	08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CRI	$ 342.14	$ 342.14
7.	08-28.0-403-055	LOT/SEC-58 PT LTS 57 & 58	$ 64,993.64	$ 64,993.64
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,940.52	$ 72,940.52

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 Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,562 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 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 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	Fire Department Connection			2008	1,685	169	10	169		716	9
10	Metro Lock& Security & Fire Alarm Door Holders			2009	2,614	214	10	214		791	10
11	Water Heater			2009	3,443	344	10	344		1,320	11
12	Kitchen Floor			2009	1,799	180	10	180		675	12
13	New Compressor			2009	1,647	110	15	110		375	13
14	Commercial Disposal			2010	1,272	254	5	254		763	14
15	P-Tec Heat Pump			2010	1,964	196	10	196		589	15
16	Replace Rooftop AC Unit			2010	4,481	448	10	448		1,307	16
17	2 Victorian Fire Doors			2011	2,500	167	15	167		208	17
18	22 Fire Doors			2011	6,688	446	15	446		557	18
19	Cabinets for new Therapy Room			2012	3,759	21	15	21		21	19
20	PTAC Unit			2012	956	159	5	159		159	20
21	5x5 PCX Gate			2012	630	84	5	84		84	21
22	Transformer, power supply			2012	2,202	147	10	147		147	22
23	Hot Water Storage Tank			2012	1,800	53	20	53		53	23
24	New Compressor & Rooftop unit			2012	13,089	436	15	436		436	24
25	100 gallon natural gas water heater			2012	3,197	27	10	27		27	25
26	4 PTAC Heat Pumps			2012	2,601	43	5	43		43	26
27	ARCH Wing - Tear out old walls & rebuild new patient rooms, therapy										27
28	room, dining area, lounge area & nurse office, drywall, paint, borders,										28
29	labor, doors, windows, electrical, lighting fixtures			2012	159,472	665	20	665		665	29
30	Power Metal Door			2012	5,530	23	20	23		23	30
31	Cabinets for new Med Room			2012	2,422	13	15	13		13	31
32	New Nurses' Stations			2012	14,775	82	15	82		82	32
33	Relocated Fire Panel			2012	3,389	28	10	28		28	33
34	Build Two New Shower Rooms - Tile, Fixtures, Walls, Labor			2012	17,907	75	20	75		75	34
35	Flooring for New ARCH Wing			2012	23,558	196	10	196		196	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation-Bridgemark Healthcare		$	$		$	$	$	37
38	New Office Build-Out	2011	23,015		20	1,219	1,219	1,772	38
39	Conference Rm Chair Rail & Paint	2012	260		5	17	17	17	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 306,655	$ 4,580		$ 5,816	$ 1,236	$ 11,142	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 83,362	$ 8,882	$ 14,572	$ 5,690	3-15	$ 31,055	71
72	Current Year Purchases	44,223	990	1,548	558	3-15	1,548	72
73	Fully Depreciated Assets	1,095					1,095	73
74								74
75	TOTALS	$ 128,680	$ 9,872	$ 16,120	$ 6,248		$ 33,698	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			$ 2,253	$	$ 564	$ 564	4	$ 2,016	76
77										77
78										78
79										79
80	TOTALS			$ 2,253	$	$ 564	$ 564		$ 2,016	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)	$ 437,588	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,452	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,500	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,048	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 46,856	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

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Four Fountains 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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		156	4/1/08	$ 771,926			3
4	Additions							4
5	Related Party Allocation-Bridgemark				18,244			5
6	Storage Rental				759			6
7	TOTAL		156		$ 790,929 **			7

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

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning 4/1/08
    Ending 3/31/18

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$ 789,165
13.	/2014	$ 806,921
14.	/2015	$ 831,129

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 68,846 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				1,064		1,064	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				246,738		246,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					31,962		31,962	12
13	Physical, Occupational & Speech Ther Other (specify): X-Rays & Labs	39,3				1,081,671			1,081,671	13
14	TOTAL			$		$ 1,081,671	$ 279,764		$ 1,361,435	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Southbelt HC # 0048587 Report 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	$ 2,275	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 57,740)	2,124,131		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,248		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,129,654	$	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	283,381		15
16	Equipment, at Historical Cost	96,729		16
17	Accumulated Depreciation (book methods)	(30,315)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	320,469		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 670,264	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,799,918	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,145,082	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,113		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,611		31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,162		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	1,372,099		36
37	Accrued Provider Assessments	125,041		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,053,108	$	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)**	$ 3,053,108	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (253,190)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,799,918	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (398,586)	1
2	Restatements (describe):		2
3	**Prior Year Depreciation Adjustment**	(78)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (398,664)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,474	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)**	$ 145,474	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)**	$ (253,190)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,251,088	1
2	Discounts and Allowances for all Levels	(124,900)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,126,188	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	238,396	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 238,396	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	5,738	13
14	Non-Patient Meals	1,572	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)**	$ 7,310	23
	D. Non-Operating Revenue		
24	Contributions	1,840	24
25	Interest and Other Investment Income***	9	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,849	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	4,514	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,514	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,378,257	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,125,011	31
32	Health Care	2,737,545	32
33	General Administration	1,549,164	33
	B. Capital Expense		
34	Ownership	974,935	34
	C. Ancillary Expense		
35	Special Cost Centers	1,389,546	35
36	Provider Participation Fee	456,582	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,232,783	40
41	**Income before Income Taxes (line 30 minus line 40)****	145,474	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 145,474	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,857,323	44
45	Private Pay - Net Inpatient Revenue	1,259,365	45
46	Medicare - Net Inpatient Revenue	2,925,273	46
47	Other-(specify) Insurance	767,651	47
48	Other-(specify) Hospice	316,576	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,126,188	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 Southbelt HC # 0048587 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,884	2,094	$ 74,510	$ 35.58	1
2	Assistant Director of Nursing	1,871	2,086	65,368	31.34	2
3	Registered Nurses	11,208	11,732	307,089	26.18	3
4	Licensed Practical Nurses	34,728	37,718	830,554	22.02	4
5	CNAs & Orderlies	85,173	91,769	1,078,604	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,903	4,222	65,965	15.62	8
9	Activity Director					9
10	Activity Assistants	5,894	6,327	85,782	13.56	10
11	Social Service Workers	1,910	2,112	33,779	15.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,501	23,039	256,076	11.11	15
16	Dishwashers					16
17	Maintenance Workers	3,433	3,830	61,171	15.97	17
18	Housekeepers	13,403	15,124	165,076	10.91	18
19	Laundry	9,572	10,327	95,744	9.27	19
20	Administrator	1,727	2,087	75,647	36.25	20
21	Assistant Administrator					21
22	Other Administrative	5,586	6,303	121,206	19.23	22
23	Office Manager	1,411	1,823	41,531	22.78	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					31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTICIAN	1,869	2,058	29,175	14.18	33
34	TOTAL (lines 1 - 33)	205,073	222,651	$ 3,387,277 *	$ 15.21	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 13,355	1,3	35
36	Medical Director		7,950	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		8,751	11,3	44
45	Social Service Consultant		2,691	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,747		49

C. CONTRACT NURSES

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

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amy Gibbs	Administrator	0	$ 75,647
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,647

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 420,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 420,200

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,025
Ceridian	Payroll Processing	17,876
Much Shelist	Legal Fees	116
Kramer & Frank	Collections - Eliminated	840
Charles Kaplan & Assoc	Collections - Eliminated	1,754
Personnel Planners	Unemployment Consultant	2,097
Allen Lefkovitz	Real Estate Tax Appeal - Reclassed to Line 33	16,407
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 43,115

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 148,270
Unemployment Compensation Insurance	172,134
FICA Taxes	261,176
Employee Health Insurance	51,679
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	5,635
Employee Benefits	12,652
Other Employee Insurance	10,517
Related Party Allocation-Bridgemark	54,054
TOTAL (agree to Schedule V, line 22, col.8)	$ 716,117

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,583
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	4,604
Dues & Subscriptions	5,564
Late Fees	1,273
Miscellaneous Licenses & Fees	1,213
Related Party Allocation-Bridgemark	636
Advertising	30,485
Less: Public Relations Expense	( )
Non-allowable advertising	(30,485)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,863

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	653
Seminar Expense	1,772
Related Pary Allocation-Bridgemark	5,915
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,340

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC # 0048587 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt HC **#** 0048587 **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 $3,153**

(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? **3-20 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,268** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **456,582**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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

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

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

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

	Description	
16A	Specialty Bed Equipment	$ 57,478
16B	Dietary Equipment	1,068
16C	Copier Lease	9,790
16D	Related Party Allocation - Bridgemark	510
		$ 68,846

Helia Southbelt Healthcare
Attachment to Schedule XVII
Other Income
12/31/2012

	Description		
16A	Medical Record Copies	$	1,834
16B	Vaccines		2,616
16C	Miscellaneous Income		64
		$	4,514