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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0048827

Facility Name: Helia Hlthcare of Belleville

Address: 40 North 64th Street (Number) Belleville (City) 62223 (Zip Code)

County: St Clair

Telephone Number: (618) 397-8400 **Fax #** (618) 397-8470

HFS ID Number:

Date of Initial License for Current Owners: 12/01/07

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 01/01/16 to 12/31/16 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) Jason Mills
(Title) Director of Corporate Accounting and IT Systems

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	122	Skilled (SNF)	122	44,652	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	122	TOTALS	122	44,652	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	20,005	738	10,002	30,745	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,005	738	10,002	30,745	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.85%

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 12/01/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 3,063

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	176,757	18,497	14,673	209,927		209,927		209,927			1
2	Food Purchase		139,133		139,133		139,133	(6,427)	132,706			2
3	Housekeeping	135,483	49,652	4,682	189,817		189,817		189,817			3
4	Laundry	19,425	43,124		62,549		62,549		62,549			4
5	Heat and Other Utilities			125,617	125,617		125,617	(10,020)	115,597			5
6	Maintenance	90,635	19,680	137,307	247,622		247,622	1	247,623			6
7	Other (specify):*											7
8	**TOTAL General Services**	422,300	270,086	282,279	974,665		974,665	(16,446)	958,219			8
	B. Health Care and Programs											
9	Medical Director			14,676	14,676		14,676		14,676			9
10	Nursing and Medical Records	1,957,235	213,079	48,334	2,218,648		2,218,648	15,146	2,233,794			10
10a	Therapy	597,047	78,651	18,035	693,733		693,733	14,216	707,949			10a
11	Activities	55,724	11,810	6,252	73,786		73,786	(1,529)	72,257			11
12	Social Services	38,937	154	3,087	42,178		42,178		42,178			12
13	CNA Training											13
14	Program Transportation			12,563	12,563		12,563		12,563			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,648,943	303,694	102,947	3,055,584		3,055,584	27,833	3,083,417			16
	C. General Administration											
17	Administrative	85,422		422,900	508,322		508,322	(384,912)	123,410			17
18	Directors Fees											18
19	Professional Services			70,196	70,196		70,196	1,956	72,152			19
20	Dues, Fees, Subscriptions & Promotions			85,770	85,770		85,770	(51,859)	33,911			20
21	Clerical & General Office Expenses	114,487	27,325	296,739	438,551		438,551	(54,710)	383,841			21
22	Employee Benefits & Payroll Taxes			497,976	497,976		497,976	29,945	527,921			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,202	4,202		4,202	5,815	10,017			24
25	Other Admin. Staff Transportation			11,448	11,448		11,448	8,209	19,657			25
26	Insurance-Prop.Liab.Malpractice			97,845	97,845		97,845	1,180	99,025			26
27	Other (specify):*											27
28	**TOTAL General Administration**	199,909	27,325	1,487,076	1,714,310		1,714,310	(444,376)	1,269,934			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,271,152	601,105	1,872,302	5,744,559		5,744,559	(432,989)	5,311,570			29

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

SEE ACCOUNTANTS' PREPARATION 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 Hlthcare of Belleville #0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			63,820	63,820		63,820	8,414	72,234			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,760	22,760		22,760	110	22,870			32
33	Real Estate Taxes			72,713	72,713		72,713	22	72,735			33
34	Rent-Facility & Grounds			686,328	686,328		686,328	11,670	697,998			34
35	Rent-Equipment & Vehicles			155,795	155,795		155,795	(43,313)	112,482			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,001,416	1,001,416		1,001,416	(23,097)	978,319			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		389,448	374,710	764,158		764,158		764,158			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,573	235,573		235,573		235,573			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		389,448	610,283	999,731		999,731		999,731			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,271,152	990,553	3,484,001	7,745,706		7,745,706	(456,086)	7,289,620			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,529)	11		4
5	Telephone, TV & Radio in Resident Rooms	(10,233)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,427)	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	(183,659)	21		18
19	Entertainment	(2,415)	21		19
20	Contributions	(593)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,879)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(30,036)	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	(22,546)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (261,071)		$	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)	(195,015)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (195,015)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (456,086)		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' PREPARATION REPORT

Helia Hlthcare of Belleville

ID# 0048827

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (20,786)	20	1
2	Eliminate Lobbying & PAC Dues	(3,181)	20	2
3	Offset Medical Record Copies	(569)	10	3
4	Include 2016 IDPH License Paid in 2015	1,990	20	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**	(22,546)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(6,427)	0	0	0	0	0	0	0	0	0	0	(6,427)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,233)	213	0	0	0	0	0	0	0	0	0	(10,020)	5
6	Maintenance	0	0	1	0	0	0	0	0	0	0	0	1	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,660)	213	1	0	0	0	0	0	0	0	0	(16,446)	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	(569)	15,707	8	0	0	0	0	0	0	0	0	15,146	10
10a	Therapy	0	0	14,216	0	0	0	0	0	0	0	0	14,216	10a
11	Activities	(1,529)	0	0	0	0	0	0	0	0	0	0	(1,529)	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**	(2,098)	15,707	14,224	0	0	0	0	0	0	0	0	27,833	16
	C. General Administration													
17	Administrative	0	(392,868)	7,956	0	0	0	0	0	0	0	0	(384,912)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,879)	4,835	0	0	0	0	0	0	0	0	0	1,956	19
20	Fees, Subscriptions & Promotions	(52,563)	688	16	0	0	0	0	0	0	0	0	(51,859)	20
21	Clerical & General Office Expenses	(186,667)	162,889	(30,932)	0	0	0	0	0	0	0	0	(54,710)	21
22	Employee Benefits & Payroll Taxes	0	24,842	5,103	0	0	0	0	0	0	0	0	29,945	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,759	56	0	0	0	0	0	0	0	0	5,815	24
25	Other Admin. Staff Transportation	0	7,391	818	0	0	0	0	0	0	0	0	8,209	25
26	Insurance-Prop.Liab.Malpractice	0	1,180	0	0	0	0	0	0	0	0	0	1,180	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(242,109)	(185,284)	(16,983)	0	0	0	0	0	0	0	0	(444,376)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(260,867)	(169,364)	(2,758)	0	0	0	0	0	0	0	0	(432,989)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,991	6,423	0	0	0	0	0	0	0	0	8,414	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(204)	0	314	0	0	0	0	0	0	0	0	110	32
33	Real Estate Taxes	0	22	0	0	0	0	0	0	0	0	0	22	33
34	Rent-Facility & Grounds	0	9,204	2,466	0	0	0	0	0	0	0	0	11,670	34
35	Rent-Equipment & Vehicles	0	0	(43,313)	0	0	0	0	0	0	0	0	(43,313)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(204)	11,217	(34,110)	0	0	0	0	0	0	0	0	(23,097)	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)**	(261,071)	(158,147)	(36,868)	0	0	0	0	0	0	0	0	(456,086)	45

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Champaign	Champaign, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Rescources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Services
		Helia Healthcare of Greenville	Greenville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Mid-South Health Care	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, 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%	$ 213	$ 213	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	15,707	15,707	2
3	V	17	Management Fees	422,900	Bridgemark Healthcare, LLC	100.00%	30,032	(392,868)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	4,835	4,835	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	688	688	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	162,889	162,889	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,842	24,842	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,759	5,759	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	7,391	7,391	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,180	1,180	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,991	1,991	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	22	22	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	9,204	9,204	13
14	Total			$ 422,900			$ 264,753	$ * (158,147)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	21	Clerical & Office Supplies	$	Bridgemark Medical Supply	100.00%	$ 61	$ 61	15
16	V	30	Depreciation		Bridgemark Medical Supply	100.00%	6,423	6,423	16
17	V	34	Building Rent		Bridgemark Medical Supply	100.00%	2,466	2,466	17
18	V	35	Equipment Rental	44,225	Bridgemark Medical Supply	100.00%		(44,225)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	912	912	24
25	V								25
26	V								26
27	V	6	Mainenance		NW Rehab, LLC	100.00%	1	1	27
28	V	10	Nursing & Medical		NW Rehab, LLC	100.00%	8	8	28
29	V	10a	Therapy	16,035	NW Rehab, LLC	100.00%	30,251	14,216	29
30	V	17	Admin Salaries		NW Rehab, LLC	100.00%	7,956	7,956	30
31	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	16	16	31
32	V	21	Clerical & Office Supplies	31,905	NW Rehab, LLC	100.00%	912	(30,993)	32
33	V	22	Employee Benefits		NW Rehab, LLC	100.00%	5,103	5,103	33
34	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	56	56	34
35	V	25	Other Admin Transportation		NW Rehab, LLC	100.00%	818	818	35
36	V	32	Interest		NW Rehab, LLC	100.00%	314	314	36
37	V								37
38	V								38
39	Total			$ 92,165			$ 55,297	$ * (36,868)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Jerseyville	Jerseyville, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	331,511	4.15	8.31	Distribution	$ 30,032	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	$ 30,032		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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	370,125	13	$ 2,569	$	30,745	$ 213	1
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	189,088	30,745	15,707	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		30,745	30,032	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		30,745	4,835	4
5	20	Dues, Subcriptions	Resident Days	370,125	13	8,280		30,745	688	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	30,745	130,891	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		30,745	31,998	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		30,745	24,842	8
9	24	Seminars	Resident Days	370,125	13	69,325		30,745	5,759	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		30,745	7,391	10
11	26	Insurance	Resident Days	370,125	13	14,200		30,745	1,180	11
12	30	Depreciation	Resident Days	370,125	13	23,966		30,745	1,991	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		30,745	22	13
14	34	Building Rent	Resident Days	370,125	13	102,424		30,745	8,508	14
15	34	Rental - Storage Unit	Resident Days	370,125	13	8,376		30,745	696	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		30,745	912	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,198,219	$ 1,764,830		$ 265,665	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Medical Supply
Street Address:
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & Office Supplies	Revenue	121,165	7	$ 168	$	44,225	$ 61	1
2	30	Depreciation	Revenue	121,165	7	17,596		44,225	6,423	2
3	34	Building Rent	Revenue	121,165	7	6,757		44,225	2,466	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	TOTALS					$ 24,521	$		$ 8,950	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: NW Rehab
Street Address:
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Revenue	2,513,226	14	$ 75	$	47,940	$ 1	1
2	10	Nursing & Medical Records	Revenue	2,513,226	14	407		47,940	8	2
3	10a	Therapy	Revenue	2,513,226	14	1,585,909	1,585,909	47,940	30,251	3
4	17	Admin Salaries	Revenue	2,513,226	14	417,103	417,103	47,940	7,956	4
5	20	Dues & Subscriptions	Revenue	2,513,226	14	864		47,940	16	5
6	21	Clerical & Office Supplies	Revenue	2,513,226	14	47,814		47,940	912	6
7	22	Employee Benefits	Revenue	2,513,226	14	267,498		47,940	5,103	7
8	24	Travel & Seminar	Revenue	2,513,226	14	2,935		47,940	56	8
9	25	Other Admin Transp	Revenue	2,513,226	14	42,896		47,940	818	9
10	32	Interest	Revenue	2,513,226	14	16,479		47,940	314	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					$ 2,381,980	$ 2,003,012		$ 45,435	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Americorp Financial, LLC			Capital Lease - Ventilators	$6,594.00	8/26/13	$ 318,568	$ 139,022	9/1/18	8.8800	$ 22,760	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Related Party Allocations										314	6
7												7
8												8
9	TOTAL Facility Related				$6,594.00		$ 318,568	$ 139,022			$ 23,074	9
	B. Non-Facility Related*											
10	Interest Income Offset										(204)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (204)	14
15	TOTALS (line 9+line14)						$ 318,568	$ 139,022			$ 22,870	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' PREPARATION 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 Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 67,272	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.)		$ 73,259	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,987	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,726	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.		$ 72,713	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	64,572	8
	2012	64,439	9
	2013	64,329	10
	2014	66,733	11
	2015	72,713	12

72,713 Line 7 Real Estate Tax portion of Lease Payment
22 Bridgemark Healthcare Allocation
72,735 Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Hlthcare of Belleville COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048827

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-12.0-213-024	Penns 2nd Bub Log/Sec-61 PT LTS	$ 72,713.34	$ 72,713.34
2.		61,62, & 64	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,713.34	$ 72,713.34

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [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 [X] (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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Plasterers			2007	6,731	337	20	337		3,366	9
10	Air Units			2007	1,215	121	10	121		1,215	10
11	Supplies For Sign			2007	1,060	106	10	106		1,060	11
12	100 Gal. Water Heater			2008	8,183	818	10	818		7,090	12
13	Vanities			2008	810	81	10	81		729	13
14	Windows			2008	1,065	53	20	53		443	14
15	Sprinklers			2008	7,898	527	15	527		4,345	15
16	Asphlalt for Rear of Building			2008	2,085	238	8	238		2,085	16
17	New Water Pump			2008	1,439	144	10	144		1,164	17
18	New Nurse's Station & Renovation of front entrance & hallways			2009	35,615	2,374	15	2,374		17,526	18
19	Asphalt for Front of Building			2009	1,295	162	8	162		1,201	19
20	Cabinets			2009	3,965	264	15	264		1,937	20
21	Carpet			2009	9,553		5			9,553	21
22	14 Doors			2009	4,382	292	15	292		2,093	22
23	Water Heater			2009	4,415	442	10	442		3,166	23
24	Cable Installation			2009	8,031	803	10	803		5,689	24
25	Wing Remodel - carpet, hand rails, paint, nurses station, plumbing doo			2010	56,248	2,812	20	2,812		17,576	25
26	Rooftop Heater & Compressor			2010	6,782	452	15	452		3,051	26
27	Cabinets for utility			2010	1,023	68	15	68		443	27
28	tile & carpet			2010	4,793		5			4,793	28
29	Countertops			2010	1,352	90	10	90		578	29
30	Facility Signage			2010	3,292	329	10	329		2,030	30
31	Kick Plates for Hallway			2010	431		5			431	31
32	A/C Units			2011	6,876	688	10	688		4,070	32
33	Shower Room - Flooring, electric, shower heads, fixtures, paint			2011	9,427	629	15	629		3,193	33
34	A/C Units			2011	6,675	541	5	541		6,675	34
35	2 Add'l cameras fro secutiry system			2012	594	119	5	119		555	35
36	New Amp Meter			2012	595	60	10	60		279	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Replace security system keypad	2012	$ 717	$ 72	10	$ 72	$	$ 330	37
38	HVAC Sytsem	2012	6,755	450	15	450		2,027	38
39	Entrance Door	2012	2,397	160	15	160		666	39
40	PTAC Units	2012	2,169	217	10	217		940	40
41	Water Heater Booster	2012	1,448	145	10	145		616	41
42	Frigidaire PTAC Units	2013	2,895	579	5	579		1,949	42
43	Radiator for Generator	2014	3,846	385	10	385		1,122	43
44	Data Cabling & Wiring	2014	2,812	281	10	281		797	44
45	Hand Rail Lumber	2014	3,486	232	15	232		619	45
46	Nurses Station POC	2014	698	140	5	140		361	46
47	Room Signs	2014	1,695	339	5	339		847	47
48	Frigidaire coor/heater	2014	739	148	5	148		370	48
49	Alarm System	2014	2,350	235	10	235		548	49
50	3 Commodes	2014	828	83	10	83		186	50
51	3 New AC Units	2014	1,901	380	5	380		982	51
52	5 PTAC units	2015	3,000	600	5	600		1,050	52
53	Ventilator monitoring system and cameras	2015	6,645	1,329	15	1,329		1,661	53
54	Tile and Backing for front sitting area & therapy room	2015	8,279	828	10	828		897	54
55	Water Heater	2015	3,910	391	10	391		391	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Related Pary Allocation - Bridgemark Halthcare LLC								63
64	New Office Build-Out	2011	11,282		20	597	597	3,259	64
65	Conference Room Chair Rail & Paint	2012	128		5	26	26	110	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 263,810	$ 19,544		$ 20,167	$ 623	$ 126,064	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 468,369	$ 40,062	$ 47,819	$ 7,757	3-15	$ 171,159	71
72	Current Year Purchases	14,615	1,297	1,331	34	3-15	1,331	72
73	Fully Depreciated Assets	63,031					63,031	73
74								74
75	TOTALS	$ 546,015	$ 41,359	$ 49,150	$ 7,791		$ 235,521	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Ford E-450	2010	$ 4,000	$	$	$	4	$ 4,000	76
77	Facility	Van	2016	20,000	2,917	2,917		4	2,917	77
78	Related Party Allocation - Bridgemark			1,104				4	1,104	78
79										79
80	TOTALS			$ 25,104	$ 2,917	$ 2,917	$		$ 8,021	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)	$ 834,929	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,820	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,234	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,414	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 369,606	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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [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:		122		$ 686,328			3
4	Additions							4
5	Related Party Allocation - Bridgemark Healthcare				9,204			5
6	Related Party Allocation - Bridgemark Medical				2,466			6
7	TOTAL		122		$ 697,998 **			7

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 112,482 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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				1,266		1,266	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				174,485		174,485	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					214,963		214,963	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				374,710			374,710	13
14	TOTAL			$		$ 374,710	$ 390,714		$ 765,424	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' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Hlthcare of Belleville **#** 0048827 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 4,835	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 517,254)	2,593,485		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	182		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,631,352		8
9	Other(specify): Deposits	135,483		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,365,337	$	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	576,221		15
16	Equipment, at Historical Cost	119,226		16
17	Accumulated Depreciation (book methods)	(288,086)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	62,259		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 469,620	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,834,957	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,174,969	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,084		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,496		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,726		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	26,107		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,411,382	$	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	Capital Lease - Ventilators	139,022		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 139,022	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,550,404	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,284,553	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,834,957	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,744,943	1
2	Restatements (describe):		2
3	**Prior Year Adjustment for Workers Comp Audit**	129,388	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,874,331	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	410,222	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)**	$ 410,222	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)**	$ 5,284,553	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 8,396,900	1
2	Discounts and Allowances for all Levels	(348,600)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,048,300	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,634	6
7	Oxygen	8,650	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 102,284	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	1,529	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)**	$ 1,529	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	204	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 204	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	3,042	28
28a	Medical Record Copies	569	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,611	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,155,928	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	974,665	31
32	Health Care	3,055,584	32
33	General Administration	1,714,310	33
	B. Capital Expense		
34	Ownership	1,001,416	34
	C. Ancillary Expense		
35	Special Cost Centers	764,158	35
36	Provider Participation Fee	235,573	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,745,706	40
41	**Income before Income Taxes (line 30 minus line 40)****	410,222	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 410,222	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,907,578	44
45	Private Pay - Net Inpatient Revenue	224,521	45
46	Medicare - Net Inpatient Revenue	1,478,342	46
47	Other-(specify) Insurance & Missouri Medicaid	2,262,088	47
48	Other-(specify) Hospice	175,771	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,048,300	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' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2,267	2,388	$ 99,790	$ 41.79	1
2	Assistant Director of Nursing	843	925	31,066	33.58	2
3	Registered Nurses	6,990	7,525	216,416	28.76	3
4	Licensed Practical Nurses	29,454	31,477	752,702	23.91	4
5	CNAs & Orderlies	60,225	64,712	810,806	12.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,808	4,093	55,724	13.61	10
11	Social Service Workers	1,639	1,823	38,937	21.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,661	16,044	176,757	11.02	15
16	Dishwashers					16
17	Maintenance Workers	3,322	3,574	90,635	25.36	17
18	Housekeepers	12,125	13,270	135,483	10.21	18
19	Laundry	2,152	2,221	19,425	8.75	19
20	Administrator	2,321	2,430	85,422	35.15	20
21	Assistant Administrator					21
22	Other Administrative	4,982	5,332	114,487	21.47	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,062	2,249	46,455	20.66	31
32	Other Health Care(specify)					32
33	Other(specify) Respiratory Ther	20,996	23,349	597,047	25.57	33
34	TOTAL (lines 1 - 33)	167,847	181,412	$ 3,271,152 *	$ 18.03	34

SEE ACCOUNTANTS' PREPARATION 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		$ 14,673	1,3	35
36	Medical Director		14,676	9,3	36
37	Medical Records Consultant		1,836	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,164	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		2,000	10a,3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		6,252	11,3	44
45	Social Service Consultant		3,087	12,3	45
46	Other(specify) Psych Consultant		860	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 50,548		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	138	$ 8,419	10,3	50
51	Licensed Practical Nurses	31	1,540	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	169	$ 9,959		53

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karlene Dotson	Administrator	0	$ 85,422
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,422

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 422,900
TOTAL (agree to Schedule V, line 17, col. 3)	$ 422,900
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 3,775
Paycom Payroll, LLC	Payroll Processing	21,008
Personnel Planners, Inc.	Unemployment Consulting	1,757
Kramer & Frank, P.C.	Collection Fees	2,879
O'Halloran Kosoff Geitner & Co	Legal Fees	2,560
Much Shelist	Legal Fees	31,796
HK Payroll Services	WOTC Program	1,240
Lamont Hanley & Assoc	Legal Fees	5,181
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 70,196

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,517
Unemployment Compensation Insurance	80,305
FICA Taxes	246,114
Employee Health Insurance	28,570
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	5,288
Employee Benefits	6,182
Other Employee Insurance	
Related Party Allocation - Bridgemark	24,842
Related Party Allocation - NW Rehab	5,103
TOTAL (agree to Schedule V, line 22, col.8)	$ 527,921

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	7,024
Health Care Worker Background Check	2,795
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	4,966
Late Fees	15,489
Miscellaneous Licenses & Fees	943
Advertising	30,036
Related Party Allocations	704
Less: Public Relations Expense	( )
Non-allowable advertising	(30,036)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,911

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14
Seminar Expense	4,188
Related Party Allocation - Bridgemark	5,759
Related Party Allocation - NW Rehab	56
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,017

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Hlthcare of Belleville # 0048827 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,871**

(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. $ **33,285** 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. $ **235,573**
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' PREPARATION 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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,529**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Helia Healthcare of Belleville
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

	Description	
16A	Specialty Bed Rental	102,829
16B	Respiratory Equipment	2,465
16C	Copier Lease	6,276
16D	Related Party Allocation - Bridgemark Healthcare	912
		112,482

Account ID	Account Description	Date	Reference	Jrnl	Job Title	Trans Description	Debit Amt
90652	Travel: Mileage/Fuel	1/4/16	010416	PJ	Director of Admissions	Sharon Wagner - December expense report	201.84
90652	Travel: Mileage/Fuel	1/7/16	010716	PJ	Asst. Director of Nursing	Cindy Bingham - December expense report	150.18
90652	Travel: Mileage/Fuel	1/7/16	010716	PJ	Director of Maintenance	Andrew Verdu - December expense report	45.90
90652	Travel: Mileage/Fuel	1/12/16	011216	PJ		Circle K - gas for van	43.00
90652	Travel: Mileage/Fuel	1/14/16	011416	PJ		Circle K - gas for van	53.01
90652	Travel: Mileage/Fuel	1/18/16	KD: 2016-01-18	CDJ	Administrator	- Auto Mileage	43.94
90652	Travel: Mileage/Fuel	1/27/16	012716	PJ		Circle K - gas for van	35.00
90652	Travel: Mileage/Fuel	2/2/16	020216	PJ	Asst. Director of Nursing	Cindy Bingham - 1/16 expense	55.72
90652	Travel: Mileage/Fuel	2/2/16	020216	PJ	Director of Admissions	Sharon Wagner - 1/16 expense	177.05
90652	Travel: Mileage/Fuel	2/2/16	020216	PJ	Director of Social Services	Kendra Collins - 1/16 expenses	61.49
90652	Travel: Mileage/Fuel	2/8/16	020816	PJ		Circle K - gas	47.00
90652	Travel: Mileage/Fuel	2/12/16	021216	PJ	Director of Maintenance	Andrew Verdu - 1/16 expenses	414.58
90652	Travel: Mileage/Fuel	2/17/16	021716	PJ	Culinary Director	Nancy Whitworth - expense report	43.90
90652	Travel: Mileage/Fuel	2/23/16	022316	PJ		Circle K	50.00
90652	Travel: Mileage/Fuel	2/29/16	022916	PJ	C.N.A.	Rita Pannier - 1/16 expenses	86.40
90652	Travel: Mileage/Fuel	3/1/16	0301616	PJ	Director of Social Services	Kendra Collins - expenses for 2/16	43.07
90652	Travel: Mileage/Fuel	3/2/16	030216	PJ		Circle K - gas	61.00
90652	Travel: Mileage/Fuel	3/2/16	030216	PJ	Director of Admissions	Sharon Wagner - 2/16 expenses	73.33
90652	Travel: Mileage/Fuel	3/2/16	030216	PJ	Asst. Director of Nursing	Cindy Bingham - 2.16 expenses	105.20
90652	Travel: Mileage/Fuel	3/3/16	030316	PJ	Director of Maintenance	Andrew Verdu - 2/16 expenses	125.42
90652	Travel: Mileage/Fuel	3/18/16	031816	PJ	MDS Coordinator	Celeena West - Expense report/mileage for DON meeting	100.44
90652	Travel: Mileage/Fuel	3/23/16	032316	PJ		Circle K - gas	57.00
90652	Travel: Mileage/Fuel	4/1/16	KD: 2016-03-14	CDJ	Administrator	- Auto: Mileage	25.06
90652	Travel: Mileage/Fuel	5/1/16	040116	PJ	Asst. Director of Nursing	Cindy Bingham - 3/16 expense	170.96
90652	Travel: Mileage/Fuel	5/1/16	040616	PJ	Culinary Director	Nancy Whitworth - 3/16 expense	26.46
90652	Travel: Mileage/Fuel	5/1/16	040716	PJ		Circle K - gas	61.15
90652	Travel: Mileage/Fuel	5/1/16	040716	PJ	Director of Social Services	Kendra Collins - 3/16 expense	117.12
90652	Travel: Mileage/Fuel	5/1/16	040716	PJ	Director of Admissions	Sharon Wagner - 3/16 expense	233.30
90652	Travel: Mileage/Fuel	5/1/16	042216	PJ		Circle K - gas	61.00
90652	Travel: Mileage/Fuel	5/1/16	042916	PJ	Director of Maintenance	Andrew Verdu	267.70
90652	Travel: Mileage/Fuel	5/1/16	042916	PJ	Director of Admissions	Sharon Wagner	200.39
90652	Travel: Mileage/Fuel	5/1/16	042916	PJ	Culinary Director	Nancy Whitworth	31.32
90652	Travel: Mileage/Fuel	5/1/16	041416	PJ	Director of Maintenance	Nathan Fogle	299.70
90652	Travel: Mileage/Fuel	5/2/16	050216	PJ	Director of Social Services	Kendra Collins - april expense report	65.66
90652	Travel: Mileage/Fuel	5/13/16	051316	PJ		Circle K - gas for van	63.01
90652	Travel: Mileage/Fuel	5/23/16	052316	PJ		Circle K - gas for van	60.00
90652	Travel: Mileage/Fuel	5/24/16	KD: 2016-05-24	CDJ	Administrator	- Auto Mileage	30.13
90652	Travel: Mileage/Fuel	6/13/16	KD: 2016-06-13	CDJ	Administrator	- Auto Mineage	14.26
90652	Travel: Mileage/Fuel	7/1/16	060316	PJ	Director of Maintenance	Andrew Verdu - expenses for May 2016	260.78
90652	Travel: Mileage/Fuel	7/1/16	060316	PJ	Director of Admissions	Sharon Wagner - may expense	256.57
90652	Travel: Mileage/Fuel	7/1/16	060616	PJ		Circle K - gas for van	70.02
90652	Travel: Mileage/Fuel	7/1/16	061416	PJ	Director of Environmental Services	Anthony Watkins	258.66
90652	Travel: Mileage/Fuel	7/1/16	062016	PJ		Circle K - gas for van	70.00
90652	Travel: Mileage/Fuel	7/1/16	062816	PJ		Circle K - gas for van	74.00
90652	Travel: Mileage/Fuel	7/5/16	070516	PJ	Director of Maintenance	Nathan Fogle	239.76
90652	Travel: Mileage/Fuel	7/5/16	070516	PJ	Activity Team Member	Timery Rogers	158.58
90652	Travel: Mileage/Fuel	7/5/16	070516	PJ	Director of Admissions	Sharon Wagner	293.38
90652	Travel: Mileage/Fuel	7/8/16	070816	PJ		Circle K - gas for van	59.00
90652	Travel: Mileage/Fuel	7/18/16	071816	PJ		Circle K - gas for van	62.00
90652	Travel: Mileage/Fuel	7/26/16	072616	PJ		Circle K - gas for van	60.00
90652	Travel: Mileage/Fuel	7/28/16	072816	PJ	Environmental Services	Marvin Murphy - mileage	189.00
90652	Travel: Mileage/Fuel	8/1/16	KD: 2016-07-11	CDJ	Administrator	- Auto Mileage	10.37
90652	Travel: Mileage/Fuel	8/2/16	080216	PJ		Circle K - gas for van	59.00
90652	Travel: Mileage/Fuel	8/2/16	080216	PJ	Director of Admissions	Sharon Wagner - july expenses	109.14
90652	Travel: Mileage/Fuel	8/2/16	080216	PJ	Director of Maintenance	Andrew Verdu - June and July epxenses	312.92
90652	Travel: Mileage/Fuel	8/8/16	080816	PJ	Culinary Director	Nancy Whitworth - expenses	27.00
90652	Travel: Mileage/Fuel	8/9/16	080916	PJ		Circle K - gas for van	52.00
90652	Travel: Mileage/Fuel	8/9/16	090916	PJ	Environmental Services	Marvin Murphy - expenses	189.00
90652	Travel: Mileage/Fuel	8/11/16	KD: 2016-08-11	CDJ	Administrator	- Auto Mileage	54.54
90652	Travel: Mileage/Fuel	8/12/16	081216	PJ		Circle K - gas for van	61.01
90652	Travel: Mileage/Fuel	8/15/16	081516	PJ	Director of Environmental Services	Anthony Watkins - expenses	93.96
90652	Travel: Mileage/Fuel	8/18/16	081816	PJ		Circle K - gas for van	73.01
90652	Travel: Mileage/Fuel	8/22/16	082216	PJ	Business Office Manager	Tracie Mittelbuscher - expenses	70.90
90652	Travel: Mileage/Fuel	8/25/16	082516	PJ		Circle K - gas for van	66.02
90652	Travel: Mileage/Fuel	8/31/16	083116	PJ	Director of Admissions	Sharon Wagner - 2 expense reports	848.50
90652	Travel: Mileage/Fuel	9/1/16	090116	PJ		Circle K - gas	58.01
90652	Travel: Mileage/Fuel	9/2/16	090216	PJ	MDS Coordinator	Lisa Yates	280.80
90652	Travel: Mileage/Fuel	9/8/16	090816	PJ		Circle K - gas	58.01
90652	Travel: Mileage/Fuel	9/17/16	091716	PJ		Circle K - gas	50.00
90652	Travel: Mileage/Fuel	9/21/16	092116	PJ		Circle K - gas	51.01
90652	Travel: Mileage/Fuel	9/28/16	092816	PJ		Circle K - gas	60.01
90652	Travel: Mileage/Fuel	9/28/16	092816	PJ	Director of Admissions	Sharon Wagner	171.18
90652	Travel: Mileage/Fuel	10/1/16	KD: 2016-09-12	CDJ	Administrator	- Auto Mileage	52.92
90652	Travel: Mileage/Fuel	10/1/16	KD: 2016-09-26	CDJ	Administrator	- AUto Mileage	198.29
90652	Travel: Mileage/Fuel	10/6/16	5908	CDJ		Circle K - Travel: Mileage/Fuel	62.00
90652	Travel: Mileage/Fuel	11/7/16	KD: 2016-11-07	CDJ	Administrator	- Auto Mileage	22.46
90652	Travel: Mileage/Fuel	11/8/16	110816	PJ	Business Office Manager	Tracie Mittelbuscher	53.84
90652	Travel: Mileage/Fuel	11/25/16	112516	PJ	Respiratory Supervisor	Crystal Chrum	72.04
90652	Travel: Mileage/Fuel	12/22/16	122216	PJ	Director of Activities	Tina Pate	75.00
90652	Travel: Mileage/Fuel	12/30/16	123016	PJ	Director of Nursing	April Pucket	102.92
90652	Travel: Mileage/Fuel	12/30/16	123016	PJ	Asst. Director of Nursing	Helen Marsh	139.17
90651	Travel: Vehicle Repairs/Tires						2,059.50
							11,447.97