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: 0048587

Facility Name: Helia Southbelt Healthcare

Address: 101 South 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 01/01/16 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 Southbelt Healthcare # 0048587 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	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	21,331	4,365	14,038	39,734	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,331	4,365	14,038	39,734	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.59%

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 10/02/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/02/08 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 7,165

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: 12/31/16 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 Southbelt Healthcare # 0048587 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	244,095	21,951	18,188	284,234		284,234		284,234			1
2	Food Purchase		224,416		224,416		224,416	(122)	224,294			2
3	Housekeeping	197,679	43,668	4,009	245,356		245,356		245,356			3
4	Laundry	81,132	30,950	2,340	114,422		114,422		114,422			4
5	Heat and Other Utilities			152,564	152,564		152,564	(16,512)	136,052			5
6	Maintenance	86,134	15,054	63,971	165,159		165,159		165,159			6
7	Other (specify):*											7
8	TOTAL General Services	609,040	336,039	241,072	1,186,151		1,186,151	(16,634)	1,169,517			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,574,941	174,417	18,006	2,767,364		2,767,364	18,875	2,786,239			10
10a	Therapy		1,839	1,252	3,091		3,091	314	3,405			10a
11	Activities	68,554	13,179	7,013	88,746		88,746		88,746			11
12	Social Services	65,933		2,761	68,694		68,694		68,694			12
13	CNA Training											13
14	Program Transportation			61,430	61,430		61,430		61,430			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,709,428	189,435	99,462	2,998,325		2,998,325	19,189	3,017,514			16
	C. General Administration											
17	Administrative	98,661		473,700	572,361		572,361	(434,475)	137,886			17
18	Directors Fees											18
19	Professional Services			37,711	37,711		37,711	4,791	42,502			19
20	Dues, Fees, Subscriptions & Promotions			88,065	88,065		88,065	(46,648)	41,417			20
21	Clerical & General Office Expenses	175,566	28,071	109,317	312,954		312,954	203,953	516,907			21
22	Employee Benefits & Payroll Taxes			541,842	541,842		541,842	32,369	574,211			22
23	Inservice Training & Education											23
24	Travel and Seminar			110	110		110	7,445	7,555			24
25	Other Admin. Staff Transportation			1,604	1,604		1,604	9,594	11,198			25
26	Insurance-Prop.Liab.Malpractice			138,201	138,201		138,201	1,524	139,725			26
27	Other (specify):*											27
28	TOTAL General Administration	274,227	28,071	1,390,550	1,692,848		1,692,848	(221,447)	1,471,401			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,592,695	553,545	1,731,084	5,877,324		5,877,324	(218,892)	5,658,432			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 Southbelt Healthcare #0048587 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			39,139	39,139		39,139	4,931	44,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,606	88,606		88,606	(1,196)	87,410			32
33	Real Estate Taxes			69,595	69,595		69,595	29	69,624			33
34	Rent-Facility & Grounds			875,945	875,945		875,945	12,800	888,745			34
35	Rent-Equipment & Vehicles			134,880	134,880		134,880	(15,057)	119,823			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,208,165	1,208,165		1,208,165	1,507	1,209,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		551,826	1,473,774	2,025,600		2,025,600		2,025,600			39
40	Barber and Beauty Shops	32,221			32,221		32,221		32,221			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			259,923	259,923		259,923		259,923			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	32,221	551,826	1,733,697	2,317,744		2,317,744		2,317,744			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,624,916	1,105,371	4,672,946	9,403,233		9,403,233	(217,385)	9,185,848			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 Southbelt Healthcare # 0048587 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				4
5	Telephone, TV & Radio in Resident Rooms	(16,788)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,212)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	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	(1,100)	20		17
18	Fines and Penalties	(2,860)	21		18
19	Entertainment	(2,242)	21		19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,458)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(37,022)	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	(10,840)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,944)		$	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)	(143,441)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (143,441)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (217,385)		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 Southbelt Healthcare

ID# 0048587

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (2,364)	20	1
2	Eliminate Lobbying & PAC Dues	(4,067)	20	2
3	Offset Medical Records Income	(1,424)	10	3
4	Eliminate IDPH Fees Disallowed	(2,985)	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**	(10,840)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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	(122)	0	0	0	0	0	0	0	0	0	0	(122)	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	(16,788)	276	0	0	0	0	0	0	0	0	0	(16,512)	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**	(16,910)	276	0	0	0	0	0	0	0	0	0	(16,634)	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	(1,424)	20,299	0	0	0	0	0	0	0	0	0	18,875	10
10a	Therapy	0	0	314	0	0	0	0	0	0	0	0	314	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,424)	20,299	314	0	0	0	0	0	0	0	0	19,189	16
	C. General Administration													
17	Administrative	0	(434,887)	412	0	0	0	0	0	0	0	0	(434,475)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,458)	6,249	0	0	0	0	0	0	0	0	0	4,791	19
20	Fees, Subscriptions & Promotions	(47,538)	889	1	0	0	0	0	0	0	0	0	(46,648)	20
21	Clerical & General Office Expenses	(5,402)	210,515	(1,160)	0	0	0	0	0	0	0	0	203,953	21
22	Employee Benefits & Payroll Taxes	0	32,105	264	0	0	0	0	0	0	0	0	32,369	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,442	3	0	0	0	0	0	0	0	0	7,445	24
25	Other Admin. Staff Transportation	0	9,552	42	0	0	0	0	0	0	0	0	9,594	25
26	Insurance-Prop.Liab.Malpractice	0	1,524	0	0	0	0	0	0	0	0	0	1,524	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(54,398)	(166,611)	(438)	0	0	0	0	0	0	0	0	(221,447)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,732)	(146,036)	(124)	0	0	0	0	0	0	0	0	(218,892)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 **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	2,573	2,358	0	0	0	0	0	0	0	0	4,931	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,212)	0	16	0	0	0	0	0	0	0	0	(1,196)	32
33	Real Estate Taxes	0	29	0	0	0	0	0	0	0	0	0	29	33
34	Rent-Facility & Grounds	0	11,895	905	0	0	0	0	0	0	0	0	12,800	34
35	Rent-Equipment & Vehicles	0	0	(15,057)	0	0	0	0	0	0	0	0	(15,057)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,212)	14,497	(11,778)	0	0	0	0	0	0	0	0	1,507	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)**	(73,944)	(131,539)	(11,902)	0	0	0	0	0	0	0	0	(217,385)	45

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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 Rescouces
		Helia Healthcare of Belleville	Belleville, IL	Bridgemark Medical Serv.	St. Louis MO	Medical Supplies
		Helia Healthcare of Greenville	Greenville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Healthcare of Olney	Olney, 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%	$ 276	$ 276	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	20,299	20,299	2
3	V	17	Management Fees	473,700	Bridgemark Healthcare, LLC	100.00%	38,813	(434,887)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	6,249	6,249	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	889	889	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	210,515	210,515	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	32,105	32,105	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,442	7,442	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	9,552	9,552	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,524	1,524	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,573	2,573	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	29	29	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	11,895	11,895	13
14	Total			$ 473,700			$ 342,161	$ * (131,539)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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%	$ 23	$ 23	15
16	V	30	Depreciation		Bridgemark Medical Supply	100.00%	2,358	2,358	16
17	V	34	Building Rent		Bridgemark Medical Supply	100.00%	905	905	17
18	V	35	Equipment Rental	16,236	Bridgemark Medical Supply	100.00%		(16,236)	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%	1,179	1,179	24
25	V								25
26	V								26
27	V								27
28	V	10a	Therapy	1,252	NW Rehab, LLC	100.00%	1,566	314	28
29	V	17	Admin Salaries		NW Rehab, LLC	100.00%	412	412	29
30	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	1	1	30
31	V	21	Clerical & Office Supplies	1,230	NW Rehab, LLC	100.00%	47	(1,183)	31
32	V	22	Employee Benefits		NW Rehab, LLC	100.00%	264	264	32
33	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	3	3	33
34	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	42	42	34
35	V	32	Interest		NW Rehab, LLC	100.00%	16	16	35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,718			$ 6,816	$ * (11,902)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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 Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, 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 Southbelt Healthcare # 0048587 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	322,730	5.37	10.74	Distribution	$ 38,813	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	$ 38,813		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 Southbelt Healthcare # 0048587 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	$	39,734	$ 276	1
2	10	Nursing & Medial Records	Resident Days	370,125	13	189,088	189,088	39,734	20,299	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		39,734	38,813	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		39,734	6,249	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280		39,734	889	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	39,734	169,161	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		39,734	41,354	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		39,734	32,105	8
9	24	Seminars	Resident Days	370,125	13	69,325		39,734	7,442	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		39,734	9,552	10
11	26	Insurance	Resident Days	370,125	13	14,200		39,734	1,524	11
12	30	Depreciation	Resident Days	370,125	13	23,966		39,734	2,573	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		39,734	29	13
14	34	Building Rent	Resident Days	370,125	13	102,424		39,734	10,996	14
15	34	Rental - Storage Unit	Resident Days	370,125	13	8,376		39,734	899	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		39,734	1,179	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		$ 343,340	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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	$	16,236	$ 23	1
2	30	Depreciation	Revenue	121,165	7	17,596		16,236	2,358	2
3	34	Building Rent	Revenue	121,165	7	6,757		16,236	905	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	$		$ 3,286	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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, LLC
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	$	2,482	$	1
2	10	Nursing & Med	Revenue	2,513,226	14	407		2,482		2
3	10a	Therapy	Revenue	2,513,226	14	1,585,909	1,585,909	2,482	1,566	3
4	17	Admin Salaries	Revenue	2,513,226	14	417,103	417,103	2,482	412	4
5	20	Dues & Subscriptions	Revenue	2,513,226	14	864		2,482	1	5
6	21	Clerical & Office Supplies	Revenue	2,513,226	14	47,814		2,482	47	6
7	22	Employee Benefits	Revenue	2,513,226	14	267,498		2,482	264	7
8	24	Travel & Seminar	Revenue	2,513,226	14	2,935		2,482	3	8
9	25	Other Admin Transp	Revenue	2,513,226	14	42,896		2,482	42	9
10	32	Interest	Revenue	2,513,226	14	16,479		2,482	16	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		$ 2,351	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding, I, LLC		X	Line of Credit		10/22/09				Variable	88,606	6
7	Related Party Allocation										16	7
8												8
9	TOTAL Facility Related						$	$			$ 88,622	9
	B. Non-Facility Related*											
10	Interest Income Offset										(1,212)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,212)	14
15	TOTALS (line 9+line14)						$	$			$ 87,410	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 Southbelt Healthcare # 0048587 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.**	$ 69,888	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.)		$ 69,551	2
3. Under or (over) accrual (line 2 minus line 1).		$ (337)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 69,932	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.		$ 69,595	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	72,941	8
	2012	65,686	9
	2013	65,600	10
	2014	66,773	11
	2015	69,034	12

69,595 Line 7, Real Estate Portion of Lease Payments
29 Bridgemark Healthcare Allocation
69,624 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 Southbelt Healthcare COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048587

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.	08-28.0-403-066	LOT/SEC-58PT LT 58	$ 546.86	$ 546.86
2.	08-28.0-403-056	LOT/SEC-58PT LOTS 57 & 58	$ 7,288.74	$ 7,288.74
3.	08-28.0-403-004	LOT/SEC-4 PT LYG S OF RICH CR	$	$
4.	08-28.0-403-003	LOT/SEC-3 PT LYG S OF RICH CR	$ 54.40	$ 54.40
5.	08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	$ 111.58	$ 111.58
6.	08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	$ 359.94	$ 359.94
7.	08-28.0-403-055	LOT/SEC-58 PT LTS 57 & 58	$ 60,672.20	$ 60,672.20
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,033.72	$ 69,033.72

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 Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/16 Ending: 12/31/16

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' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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	Fire Department Connection			2008	1,685	169	10	169		1,390	9
10	Metro Lock & Security & Fire Alarm Door Holders			2009	2,614	214	10	214		1,647	10
11	Water Heater			2009	3,443	344	10	344		2,697	11
12	Kitchen Floor			2009	1,799	180	10	180		1,394	12
13	New Compressor			2009	1,647	110	15	110		815	13
14	Commercial Disposal			2010	1,272		5			1,272	14
15	P-Tee Heat Pump			2010	1,964	196	10	196		1,374	15
16	Replace Rooftop AC Unit			2010	4,481	448	10	448		3,099	16
17	2 Victorian Fire Doors			2011	2,500	167	15	167		875	17
18	22 Fire Doors			2011	6,688	446	15	446		2,341	18
19	Cabinets for new Therapy Room			2012	3,759	251	15	251		1,024	19
20	PTAC Unit			2012	956	191	5	191		924	20
21	5X5 PCS Gate			2012	630	126	5	126		588	21
22	Transformer, Power supply			2012	2,202	220	10	220		1,028	22
23	Hot Water Storage Tank			2012	1,800	90	20	90		413	23
24	New Compressor & Rooftop unit			2012	13,089	873	15	873		3,927	24
25	100 gallon natural gas water heater			2012	3,197	320	10	320		1,306	25
26	4 PTAC Heat Pumps			2012	2,601	520	5	520		2,124	26
27	Arch Wing - Tear out old walls & rebuild new patient rooms, therapy										27
28	room, dining area, lounge are & nurse office, drywall, paint, borders,										28
29	labor, doors, windows, electrical, lighting fixtures			2012	159,472	7,974	20	7,974		32,559	29
30	Power Metal Door			2012	5,530	276	20	276		1,130	30
31	Cabinets for new Med Room			2012	2,422	161	15	161		659	31
32	New Nurses' stations			2012	14,775	985	15	985		4,022	32
33	Relocated Fire Panel			2012	3,389	339	10	339		1,384	33
34	Build 2 new shower rooms - Tile, Fixtures, Walls, Labor			2012	17,907	895	20	895		3,656	34
35	Flooring for new ARCH Wing			2012	23,558	2,356	10	2,356		9,620	35
36	Building Sign			2013	8,449	845	10	845		3,098	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 Southbelt Healthcare # 0048587 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	Nurses Station ARCH Unit	2013	$ 5,132	$ 342	15	$ 342	$	$ 1,254	37
38	Carrier Heat Pump & Fan Coil	2013	7,236	724	10	724		2,352	38
39	Amana PTAC	2013	1,183	237	5	237		829	39
40	Replace heat exchanger	2014	1,902	380	5	380		1,141	40
41	Amana PTAC	2014	2,522	504	5	504		1,366	41
42	Cabling for New Call System	2014	1,330	266	5	266		754	42
43	Installation of annunciator panel for all wings	2014	4,438	444	10	444		1,236	43
44	Roof Repair	2014	12,880	1,288	10	1,288		3,116	44
45	500 hall dining room drywall & paint	2014	1,715	171	10	171		385	45
46	Vinyl Plank Floor for 200 Hall	2015	3,485	348	10	348		523	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	Related Party Allocation - Bridgemark Healthcare LLC	2011	14,580		20	772	772	4,210	63
64	Confernece Room Chair Rail & Paint	2012	165		5	33	33	143	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 348,397	$ 23,400		$ 24,205	$ 805	$ 101,675	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 Southbelt Healthcare # 0048587 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	$ 160,863	$ 15,179	$ 19,261	$ 4,082	3-15	$ 77,736	71
72	Current Year Purchases	7,961	560	604	44	3-15	605	72
73	Fully Depreciated Assets	35,148					35,148	73
74								74
75	TOTALS	$ 203,972	$ 15,739	$ 19,865	$ 4,126		$ 113,489	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				$	$	$	$		$	76
77	Related Party Allocation - Bridgemark			1,426				4	1,426	77
78										78
79										79
80	TOTALS			$ 1,426	$	$	$		$ 1,426	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)	$ 553,795	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,139	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,070	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,931	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 216,590	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 Southbelt Healthcare # 0048587 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: 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	$ 868,809			3
4	Additions							4
5	Related Party Allocation - Bridgemark				12,800			5
6	Storage Rental				7,136			6
7	TOTAL		156		$ 888,745 **			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 by the length of the lease N/A . 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.	/2017	$ 894,874
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: $ 119,823 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 Southbelt Healthcare # 0048587 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 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				1,839		1,839	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				500,006		500,006	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					51,820		51,820	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				1,473,774			1,473,774	13
14	TOTAL			$		$ 1,473,774	$ 553,665		$ 2,027,439	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

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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	$ 10,325	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 425,290)	2,868,629		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,485		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	171,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,063,439	$	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	333,652		15
16	Equipment, at Historical Cost	143,067		16
17	Accumulated Depreciation (book methods)	(171,796)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	69,932		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 374,855	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,438,294	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,236,002	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,375		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,024		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,932		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Fees	13,901		36
37	Due to related parties	2,185,852		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,716,086	$	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)**	$ 4,716,086	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,277,792)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,438,294	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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**	$ (1,150,918)	1
2	Restatements (describe):		2
3	**Prior Year Adjustment for Workers Comp Audit**	(10,559)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,161,477)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(116,315)	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)**	$ (116,315)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,277,792)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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	$ 9,127,458	1
2	Discounts and Allowances for all Levels	(192,492)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,934,966	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	342,192	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 342,192	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,212	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,212	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	1,424	28
28a	Miscellaneous	7,124	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,548	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,286,918	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,186,151	31
32	Health Care	2,998,325	32
33	General Administration	1,692,848	33
	B. Capital Expense		
34	Ownership	1,208,165	34
	C. Ancillary Expense		
35	Special Cost Centers	2,057,821	35
36	Provider Participation Fee	259,923	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,403,233	40
41	**Income before Income Taxes (line 30 minus line 40)****	(116,315)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (116,315)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,798,385	44
45	Private Pay - Net Inpatient Revenue	887,232	45
46	Medicare - Net Inpatient Revenue	3,360,651	46
47	Other-(specify) Insurance	1,559,227	47
48	Other-(specify) Hospice	329,471	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,934,966	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 Southbelt Healthcare # 0048587 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	1,675	2,032	$ 81,060	$ 39.89	1
2	Assistant Director of Nursing	2,036	2,215	71,429	32.25	2
3	Registered Nurses	14,927	16,095	492,009	30.57	3
4	Licensed Practical Nurses	28,249	30,151	753,399	24.99	4
5	CNAs & Orderlies	78,095	83,741	1,087,855	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,853	4,421	81,492	18.43	8
9	Activity Director					9
10	Activity Assistants	4,091	4,693	68,554	14.61	10
11	Social Service Workers	3,278	3,498	65,933	18.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,501	20,703	244,095	11.79	15
16	Dishwashers					16
17	Maintenance Workers	3,774	4,290	86,134	20.08	17
18	Housekeepers	14,355	16,029	197,679	12.33	18
19	Laundry	7,182	7,823	81,132	10.37	19
20	Administrator	1,985	2,116	98,661	46.63	20
21	Assistant Administrator					21
22	Other Administrative	3,756	4,243	98,295	23.17	22
23	Office Manager					23
24	Clerical	4,329	4,844	77,271	15.95	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	470	541	7,697	14.23	31
32	Other Health Care(specify)					32
33	Other(specify) Beautician	1,760	2,017	32,221	15.97	33
34	TOTAL (lines 1 - 33)	193,316	209,452	$ 3,624,916 *	$ 17.31	34

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* 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		$ 18,188	1,3	35
36	Medical Director		9,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,066	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		7,013	11,3	44
45	Social Service Consultant		2,761	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 46,028		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian L. Koontz	Adminstrator	0	$ 98,661
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,661

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 473,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 473,700
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting Services	$ 3,775
Paycom Payroll, LLC	Payroll Processing	21,995
Personnel Planners, Inc.	Unemployment Consulting	3,967
Kramer & Frank PC	Collection Fees - Eliminated	60
Lamont, Hanley, & Assoc, Inc.	Collection Fees - Eliminated	548
Much Shelist	Legal Fees	6,516
Kramer & Frank PC	Collection Fees - Eliminated	850
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 37,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 147,277
Unemployment Compensation Insurance	86,857
FICA Taxes	274,496
Employee Health Insurance	23,885
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	8,445
Employee Benefits	385
Other Employee Insurance	497
Related Party Allocation - Bridgemark	32,105
Related Party Allocation - NW Rehab	264
TOTAL (agree to Schedule V, line 22, col.8)	$ 574,211

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	6,641
Health Care Worker Background Check	6,341
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	9,041
Late Fees	16,088
Miscellaneous Licenses & Fees	426
Advertising	37,022
Related Party Allocations	890
Less: Public Relations Expense	( )
Non-allowable advertising	(37,022)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,417

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	110
Related Party Allocation - Bridgemark	7,442
Related Party Allocation - NW Rehab	3
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,555

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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 $6,229**

(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. $ **22,907** 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. $ **259,923**
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? **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) 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 Southbelt Healthcare
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

	Description	
16A	Specialty Bed Rental	110,500
16B	Dietary Equipment	1,068
16C	Copier Lease	7,076
16D	Related Party Allocation - Bridgemark Healthcare	1,179
		119,823