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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 01/01/17 to 12/31/17 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) Chief Financial Officer

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: 01/01/17 Ending: 12/31/17

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	56,940	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	56,940	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	21,415	2,401	12,829	36,645	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,415	2,401	12,829	36,645	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.36%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 6,636

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: 12/31/17 Fiscal Year: 12/31/17

* 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: 01/01/17 Ending: 12/31/17

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	234,816	20,320	26,807	281,943		281,943		281,943			1
2	Food Purchase		232,949		232,949		232,949	(76)	232,873			2
3	Housekeeping	197,477	48,363	4,840	250,680		250,680		250,680			3
4	Laundry	75,236	25,549	2,145	102,930		102,930		102,930			4
5	Heat and Other Utilities			153,594	153,594		153,594	(17,449)	136,145			5
6	Maintenance	88,901	21,963	60,587	171,451		171,451		171,451			6
7	Other (specify):*											7
8	**TOTAL General Services**	596,430	349,144	247,973	1,193,547		1,193,547	(17,525)	1,176,022			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,512,519	183,184	56,403	2,752,106		2,752,106	32,286	2,784,392			10
10a	Therapy		1,671		1,671		1,671	4,633	6,304			10a
11	Activities	73,054	10,857	7,146	91,057		91,057		91,057			11
12	Social Services	55,052	272	2,856	58,180		58,180		58,180			12
13	CNA Training											13
14	Program Transportation			56,233	56,233		56,233		56,233			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,640,625	195,984	131,638	2,968,247		2,968,247	36,919	3,005,166			16
	C. General Administration											
17	Administrative	73,894		449,500	523,394		523,394	(369,581)	153,813			17
18	Directors Fees											18
19	Professional Services			28,991	28,991		28,991	22,322	51,313			19
20	Dues, Fees, Subscriptions & Promotions			185,014	185,014		185,014	(36,504)	148,510			20
21	Clerical & General Office Expenses	184,304	25,076	132,193	341,573		341,573	189,433	531,006			21
22	Employee Benefits & Payroll Taxes			451,376	451,376		451,376	29,213	480,589			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,145	4,145		4,145	9,215	13,360			24
25	Other Admin. Staff Transportation			4,792	4,792		4,792	9,542	14,334			25
26	Insurance-Prop.Liab.Malpractice			156,493	156,493		156,493	2,717	159,210			26
27	Other (specify):*											27
28	**TOTAL General Administration**	258,198	25,076	1,412,504	1,695,778		1,695,778	(143,643)	1,552,135			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,495,253	570,204	1,792,115	5,857,572		5,857,572	(124,249)	5,733,323			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: 01/01/17 Ending: 12/31/17

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			37,998	37,998		37,998	4,500	42,498			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,080	115,080		115,080	(599)	114,481			32
33	Real Estate Taxes			99,448	99,448		99,448	27	99,475			33
34	Rent-Facility & Grounds			894,874	894,874		894,874	10,295	905,169			34
35	Rent-Equipment & Vehicles			143,108	143,108		143,108	(1,211)	141,897			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,290,508	1,290,508		1,290,508	13,012	1,303,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		574,043	1,499,700	2,073,743		2,073,743	(2,648)	2,071,095			39
40	Barber and Beauty Shops	20,386			20,386		20,386		20,386			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			268,815	268,815		268,815		268,815			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	20,386	574,043	1,768,515	2,362,944		2,362,944	(2,648)	2,360,296			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,515,639	1,144,247	4,851,138	9,511,024		9,511,024	(113,885)	9,397,139			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: 01/01/17 Ending: 12/31/17

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	(17,767)	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	(664)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	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	(1,850)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,069)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(131)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(30,306)	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	(6,375)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,238)		$	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)	(52,647)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (52,647)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (113,885)		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: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (2,368)	20	1
2	To Offset Medical Record Income	(913)	10	2
3	To Eliminate Lobbying & PAC Dues	(3,094)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,375)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(76)	0	0	0	0	0	0	0	0	0	0	(76)	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	(17,767)	318	0	0	0	0	0	0	0	0	0	(17,449)	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**	(17,843)	318	0	0	0	0	0	0	0	0	0	(17,525)	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	(913)	33,199	0	0	0	0	0	0	0	0	0	32,286	10
10a	Therapy	0	0	4,633	0	0	0	0	0	0	0	0	4,633	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**	(913)	33,199	4,633	0	0	0	0	0	0	0	0	36,919	16
	C. General Administration													
17	Administrative	0	(370,772)	1,191	0	0	0	0	0	0	0	0	(369,581)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(131)	22,453	0	0	0	0	0	0	0	0	0	22,322	19
20	Fees, Subscriptions & Promotions	(37,618)	1,114	0	0	0	0	0	0	0	0	0	(36,504)	20
21	Clerical & General Office Expenses	(4,069)	196,631	(3,129)	0	0	0	0	0	0	0	0	189,433	21
22	Employee Benefits & Payroll Taxes	0	28,384	829	0	0	0	0	0	0	0	0	29,213	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,168	47	0	0	0	0	0	0	0	0	9,215	24
25	Other Admin. Staff Transportation	0	9,407	135	0	0	0	0	0	0	0	0	9,542	25
26	Insurance-Prop.Liab.Malpractice	0	2,707	10	0	0	0	0	0	0	0	0	2,717	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(41,818)	(100,908)	(917)	0	0	0	0	0	0	0	0	(143,643)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,574)	(67,391)	3,716	0	0	0	0	0	0	0	0	(124,249)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Helia Southbelt Healthcare** **#** **0048587** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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**	**2,116**	**2,384**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,500**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**(664)**	**0**	**65**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(599)**	**32**
33	Real Estate Taxes	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27**	**33**
34	Rent-Facility & Grounds	**0**	**10,013**	**282**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10,295**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**(1,211)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,211)**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**(664)**	**12,156**	**1,520**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13,012**	**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**	**(2,648)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(2,648)**	**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**	**(2,648)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(2,648)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(61,238)**	**(55,235)**	**2,588**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(113,885)**	**45**

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Belleville	Belleville, IL	Bridgemark Medical S	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 Clin	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%	$ 318	$ 318	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	33,199	33,199	2
3	V	17	Management Fees	449,500	Bridgemark Healthcare, LLC	100.00%	78,728	(370,772)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	22,453	22,453	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,114	1,114	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	196,631	196,631	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	28,384	28,384	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	9,168	9,168	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	9,407	9,407	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,707	2,707	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,116	2,116	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	27	27	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	10,013	10,013	13
14	Total			$ 449,500			$ 394,265	$ * (55,235)	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: 01/01/17 Ending: 12/31/17

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	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 941	$ 941	15
16	V								16
17	V								17
18	V	30	Depreciation		Bridgemark Medical Supply	100.00%	2,384	2,384	18
19	V	34	Building Rent		Bridgemark Medical Supply	100.00%	282	282	19
20	V	35	Equipment Rental	2,152	Bridgemark Medical Supply	100.00%		(2,152)	20
21	V								21
22	V	10a	Therapy		NW Rehab, LLC	100.00%	4,633	4,633	22
23	V	17	Admin Salaries		NW Rehab, LLC	100.00%	1,191	1,191	23
24	V	21	Clerical & Office Supplies	3,217	NW Rehab, LLC	100.00%	88	(3,129)	24
25	V	22	Employee Benefits		NW Rehab, LLC	100.00%	829	829	25
26	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	47	47	26
27	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	135	135	27
28	V	26	Insurance - Prop Liab, Malprac		NW Rehab, LLC	100.00%	10	10	28
29	V	32	Interest		NW Rehab, LLC	100.00%	65	65	29
30	V	39	Ancillary Services	2,648	NW Rehab, LLC	100.00%		(2,648)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,017			$ 10,605	$ * 2,588	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: 01/01/17 Ending: 12/31/17

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

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	698,060	5.07	10.14	Distribution	$ 78,728	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	$ 78,728		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

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	361,568	13	$ 3,142	$	36,645	$ 318	1
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	36,645	33,199	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788		36,645	78,728	3
4	19	Professional Fees	Resident Days	361,568	13	221,539		36,645	22,453	4
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991		36,645	1,114	5
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	36,645	158,221	6
7	21	Clercial & Office Supplies	Resident Days	361,568	13	378,981		36,645	38,410	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058		36,645	28,384	8
9	24	Seminars	Resident Days	361,568	13	90,455		36,645	9,168	9
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816		36,645	9,407	10
11	26	Insurance	Resident Days	361,568	13	26,711		36,645	2,707	11
12	30	Depreciation	Resident Days	361,568	13	20,874		36,645	2,116	12
13	33	Real Estate Taxes	Resident Days	361,568	13	269		36,645	27	13
14	34	Building Rent	Resident Days	361,568	13	95,732		36,645	9,702	14
15	34	Rental - Storage Unit	Resident Days	361,568	13	3,073		36,645	311	15
16	35	Equipment Rental	Resident Days	361,568	13	9,286		36,645	941	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,899,417	$ 1,888,702		$ 395,206	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						$	$		$	1
2	30	Depreciation	Revenue	70,485	7	17,596		9,548	2,384	2
3	34	Building Rent	Revenue	70,485	7	2,079		9,548	282	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					$ 19,675	$		$ 2,666	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						$	$		$	1
2	10	Nuring & Med	Revenue	2,581,783	19	73		7,425		2
3	10a	Therapy	Revenue	2,581,783	19	1,610,941	1,610,941	7,425	4,633	3
4	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	7,425	1,191	4
5	20	Dues & Subscriptions	Revenue	2,581,783	19	136		7,425		5
6	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456		7,425	88	6
7	22	Employee Benefits	Revenue	2,581,783	19	288,251		7,425	829	7
8	24	Travel & Seminar	Revenue	2,581,783	19	16,377		7,425	47	8
9	25	Other Amin Transp	Revenue	2,581,783	19	46,860		7,425	135	9
10	26	Insurance - Prop Liab, Malprac	Revenue	2,581,783	19	3,500		7,425	10	10
11	32	Interest	Revenue	2,581,783	19	22,721		7,425	65	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					$ 2,433,379	$ 2,025,005		$ 6,998	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	115,080	6
7	Related Party Allocation										65	7
8												8
9	TOTAL Facility Related						$	$			$ 115,145	9
	B. Non-Facility Related*											
10	Interest Income Offset										(664)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (664)	14
15	TOTALS (line 9+line14)						$	$			$ 114,481	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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 69,932	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.)		$ 87,057	2
3. Under or (over) accrual (line 2 minus line 1).		$ 17,125	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 82,323	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.		$ 99,448	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	65,686	8
	2013	65,600	9
	2014	66,773	10
	2015	69,034	11
	2016	82,323	12

99,448	Line 7, Real Estate Portion of Lease Payments	2017 Taxes Paid	$82,323
27	Bridgemark Healthcare Allocation	PY Adjustment	4,734
99,475	Total Schedule V, Line 33		87,057

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(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	$ 564.80	$ 564.80
2.	08-28.0-403-056	LOT/SEC-58PT LOTS 57 & 58	$ 5,270.28	$ 5,270.28
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	$ 52.40	$ 52.40
5.	08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	$ 107.46	$ 107.46
6.	08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	$ 347.02	$ 347.02
7.	08-28.0-403-055	LOT/SEC-58 PT LTS 57 & 58	$ 75,981.10	$ 75,981.10
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,323.06	$ 82,323.06

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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		1,559	9
10	Metro Lock & Security & Fire Alarm Door Holders			2009	2,614	214	10	214		1,861	10
11	Water Heater			2009	3,443	344	10	344		3,041	11
12	Kitchen Floor			2009	1,799	180	10	180		1,574	12
13	New Compressor			2009	1,647	110	15	110		924	13
14	Commercial Disposal			2010	1,272		5			1,272	14
15	P-Tee Heat Pump			2010	1,964	196	10	196		1,571	15
16	Replace Rooftop AC Unit			2010	4,481	448	10	448		3,547	16
17	2 Victorian Fire Doors			2011	2,500	167	15	167		1,042	17
18	22 Fire Doors			2011	6,688	446	15	446		2,787	18
19	Cabinets for new Therapy Room			2012	3,759	251	15	251		1,274	19
20	PTAC Unit			2012	956	32	5	32		956	20
21	5x5 PCS Gate			2012	630	42	5	42		630	21
22	Transformer, Power Supply			2012	2,202	220	10	220		1,248	22
23	Hot Water Storage Tank			2012	1,800	90	20	90		503	23
24	New Compressor & Rooftop unit			2012	13,089	873	15	873		4,799	24
25	100 Gallon naterial gas water heater			2012	3,197	320	10	320		1,625	25
26	4 PTAC Heat Pumps			2012	2,601	477	5	477		2,601	26
27	Arch Wing - Tear out old walls & rebuild new patient rooms, therapy room,										27
28	(cont.) dining area, lounge area & nurse office, drywall, paint, borders labor										28
29	(cont.) doors, windows, electrical, lighting fixtures			2012	159,472	7,974	20	7,974		40,532	29
30	Power Metal Door			2012	5,530	277	20	277		1,406	30
31	Cabinets for New Med Room			2012	2,422	161	15	161		821	31
32	New Nurses' Station			2012	14,775	985	15	985		5,007	32
33	Relocated Fire Panel			2012	3,389	339	10	339		1,723	33
34	Build 2 new shower rooms - Tile, Fixtures, Walls, Labor			2012	17,907	895	20	895		4,551	34
35	Flooring for new ARCH Wing			2012	23,558	2,356	10	2,356		11,975	35
36	Building Sign			2013	8,449	845	10	845		3,943	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	$ 1,597	37
38	carrier Heat Pump & Fan Coil	2013	7,236	724	10	724		3,075	38
39	Amana PTAC	2013	1,183	236	5	236		1,065	39
40	Replace heat exchanger	2014	1,902	380	5	380		1,522	40
41	Amana PTAC	2014	2,522	504	5	504		1,871	41
42	Cabling for New Call System	2014	1,330	266	5	266		1,020	42
43	Installation of annuciator panel for all wings	2014	4,438	444	10	444		1,681	43
44	Roof Repair	2014	12,880	1,288	10	1,288		4,404	44
45	500 Hall dining room drywall & paint	2014	1,715	171	10	171		557	45
46	Vinyl Plank Floor for 200 Hall	2015	3,485	348	10	348		871	46
47	Roof Repairs from Storm Damage	2017	3,500	262	10	262		263	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55	Related Party Allocation - Bridgemark Healthcare								55
56	New Office Build Out	2011	13,765		20	729	729	4,704	56
57	Conference Rm Chair Rail & Paint	2012	156		5	21	21	156	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 351,073	$ 23,376		$ 24,126	$ 750	$ 125,558	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: 01/01/17 Ending: 12/31/17

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	$ 161,300	$ 11,993	$ 15,743	$ 3,750	3-15 Yrs	$ 86,634	71
72	Current Year Purchases	3,070	185	185		3-15 Yrs	185	72
73	Fully Depreciated Assets	42,008					42,008	73
74								74
75	TOTALS	$ 206,378	$ 12,178	$ 15,928	$ 3,750		$ 128,827	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	Van		2017	$ 7,500	$ 1,250	$ 1,250	$	4	$ 1,250	76
77	2005 Chevy Truck		2017	7,164	1,194	1,194		4	1,194	77
78										78
79	Related Party Allocation -- Bridgemark Healthcare			1,347				4	1,347	79
80	TOTALS			$ 16,011	$ 2,444	$ 2,444	$		$ 3,791	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)	$ 573,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,998	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 42,498	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,500	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 258,176	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.

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 894,874			3
4	Additions							4
5	Storage Rental							5
6	Related Party Allocations				10,295			6
7	TOTAL		156		$ 905,169 **			7

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 141,897 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: 01/01/17 Ending: 12/31/17

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

Facility Name & ID Number Helia Southbelt Healthcare

STATE OF ILLINOIS
0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				1,671		1,671	3
4	Licensed Physical Therapist	10a,2	hrs							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				534,564		534,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					39,479		39,479	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				1,499,700			1,499,700	13
14	TOTAL			$		$ 1,499,700	$ 575,714		$ 2,075,414	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 Southbelt Healthcare **#** 0048587 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,338	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,433)	2,690,773		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	88,891		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	18,306		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,799,308	$	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	337,152		15
16	Equipment, at Historical Cost	160,276		16
17	Accumulated Depreciation (book methods)	(209,794)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	52,470		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 340,104	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,139,412	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,365,413	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	232,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	(4,463)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,323		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	19,338		36
37	Due to Related Parties	2,378,940		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,073,986	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	115,491		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)**	$ 115,491	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,189,477	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,050,065)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,139,412	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,277,792)	1
2	Restatements (describe):		2
3			3
4	**Prior Year Adjustment after Cost Report Issued**	(7,731)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,285,523)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(764,542)	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)**	$ (764,542)	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)**	$ (2,050,065)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 8,685,123	1
2	Discounts and Allowances for all Levels	(208,400)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,476,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	217,845	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 217,845	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***	664	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 664	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	913	28
28a	Miscellaneous Income	50,337	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,250	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,746,482	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,193,547	31
32	Health Care	2,968,247	32
33	General Administration	1,695,778	33
	B. Capital Expense		
34	Ownership	1,290,508	34
	C. Ancillary Expense		
35	Special Cost Centers	2,094,129	35
36	Provider Participation Fee	268,815	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,511,024	40
41	**Income before Income Taxes (line 30 minus line 40)****	(764,542)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (764,542)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,953,435	44
45	Private Pay - Net Inpatient Revenue	466,290	45
46	Medicare - Net Inpatient Revenue	3,078,912	46
47	Other-(specify) Insurance	1,834,641	47
48	Other-(specify) Hospice	143,445	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,476,723	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: 01/01/17 Ending: 12/31/17

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	2,003	2,178	$ 82,908	$ 38.07	1
2	Assistant Director of Nursing	2,050	2,167	80,646	37.22	2
3	Registered Nurses	10,970	11,633	376,390	32.36	3
4	Licensed Practical Nurses	28,561	30,444	817,296	26.85	4
5	CNAs & Orderlies	78,031	83,701	1,132,018	13.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	37	40	779	19.48	8
9	Activity Director					9
10	Activity Assistants	4,344	4,787	73,054	15.26	10
11	Social Service Workers	2,642	2,924	55,052	18.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,061	20,461	234,816	11.48	15
16	Dishwashers					16
17	Maintenance Workers	3,782	4,307	88,901	20.64	17
18	Housekeepers	14,259	15,579	197,477	12.68	18
19	Laundry	5,912	6,524	75,236	11.53	19
20	Administrator	1,148	1,439	73,894	51.35	20
21	Assistant Administrator					21
22	Other Administrative	7,592	8,317	184,304	22.16	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	1,407	1,526	22,482	14.73	31
32	Other Health Care(specify)					32
33	Other(specify)	1,043	1,234	20,386	16.52	33
34	TOTAL (lines 1 - 33)	182,842	197,261	$ 3,515,639 *	$ 17.82	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		$ 26,807	1,3	35
36	Medical Director		9,000	9,3	36
37	Medical Records Consultant		720	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,149	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		7,146	11,3	44
45	Social Service Consultant		2,856	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 55,678		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	45	$ 2,721	10,3	50
51	Licensed Practical Nurses	220	10,771	10,3	51
52	Certified Nurse Assistants/Aides	899	22,479	10,3	52
53	TOTAL (lines 50 - 52)	1,164	$ 35,971		53

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian L. Koontz	Administrator	0	$ 34,004
Stephanie Birch	Administrator	0	39,890
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,894

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 449,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 449,500

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 1,092
Personal Planners	Unemployment Consulting	1,555
Riordan, Fulkerson, Hupert & Coleman	Legal Fees	1,750
Much Shelist	Legal Fees	2,845
Paycom Payroll	Payroll Processing	21,146
	Professional Services	472
	Collections - Eliminated	131
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 28,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,353
Unemployment Compensation Insurance	59,754
FICA Taxes	264,980
Employee Health Insurance	12,138
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	9,108
Employee Benefits	1,896
Other Employee Insurance	147
Related Party Allocation - Bridgemark	28,384
Related Party Allocation - NW Rehab	829
TOTAL (agree to Schedule V, line 22, col.8)	$ 480,589

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	8,138
Health Care Worker Background Check	5,397
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscription	12,995
Late Fees	118,076
Miscellaneous Licenses & Fees	800
Advertising	30,306
Related Party Allocation - Bridgemark	1,114
Less: Public Relations Expense	( )
Non-allowable advertising	(30,306)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 148,510

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	977
Seminar Expense	3,168
Related Party Allocation - Bridgemark	9,168
Related Party Allocation - NW Rehab	47
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,360

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 $7,202**

(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. $ **26,237** 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. $ **268,815**
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	113,007
16B	Copier Lease	15,453
16C	Related Party Allocation - Bridgemark Healthcare	941
16D	Computer & Printer Rental	10,789
16E	Storage	1,707
		141,897