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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 01/01/2018 to 12/31/2018 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
(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: 01/01/2018 Ending: 12/31/2018

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	22,469	1,998	11,286	35,753	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,469	1,998	11,286	35,753	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.79%

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 5,728

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* 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: 01/01/2018 Ending: 12/31/2018

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	239,859	17,492	25,523	282,874		282,874		282,874			1
2	Food Purchase		226,960		226,960		226,960	(63)	226,897			2
3	Housekeeping	198,222	34,199	6,236	238,657		238,657		238,657			3
4	Laundry	73,838	29,220	390	103,448		103,448		103,448			4
5	Heat and Other Utilities			155,801	155,801		155,801	(17,767)	138,034			5
6	Maintenance	85,815	22,747	58,533	167,095		167,095		167,095			6
7	Other (specify):*											7
8	TOTAL General Services	597,734	330,618	246,483	1,174,835		1,174,835	(17,830)	1,157,005			8
	B. Health Care and Programs											
9	Medical Director			72,956	72,956		72,956		72,956			9
10	Nursing and Medical Records	2,542,747	194,102	58,829	2,795,678		2,795,678	24,074	2,819,752			10
10a	Therapy		1,950		1,950		1,950	723	2,673			10a
11	Activities	76,714	10,053	7,628	94,395		94,395		94,395			11
12	Social Services	118,886		2,705	121,591		121,591		121,591			12
13	CNA Training											13
14	Program Transportation			49,748	49,748		49,748		49,748			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,738,347	206,105	191,866	3,136,318		3,136,318	24,797	3,161,115			16
	C. General Administration											
17	Administrative	113,135		351,800	464,935		464,935	(323,490)	141,445			17
18	Directors Fees											18
19	Professional Services			42,790	42,790		42,790	21,621	64,411			19
20	Dues, Fees, Subscriptions & Promotions			64,875	64,875		64,875	(36,471)	28,404			20
21	Clerical & General Office Expenses	210,778	34,283	136,038	381,099		381,099	194,851	575,950			21
22	Employee Benefits & Payroll Taxes			442,231	442,231		442,231	24,106	466,337			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,924	1,924		1,924	7,033	8,957			24
25	Other Admin. Staff Transportation			9,789	9,789		9,789	8,155	17,944			25
26	Insurance-Prop.Liab.Malpractice			152,946	152,946		152,946	1,438	154,384			26
27	Other (specify):*											27
28	TOTAL General Administration	323,913	34,283	1,202,393	1,560,589		1,560,589	(102,757)	1,457,832			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,659,994	571,006	1,640,742	5,871,742		5,871,742	(95,790)	5,775,952			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: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			37,597	37,597		37,597	2,017	39,614			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,597	129,597		129,597	(7,589)	122,008			32
33	Real Estate Taxes			81,405	81,405		81,405	71	81,476			33
34	Rent-Facility & Grounds			674,272	674,272		674,272	10,345	684,617			34
35	Rent-Equipment & Vehicles			88,163	88,163		88,163	945	89,108			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,011,034	1,011,034		1,011,034	5,789	1,016,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		418,012	1,237,103	1,655,115		1,655,115	(1,050)	1,654,065			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,894	279,894		279,894		279,894			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		418,012	1,516,997	1,935,009		1,935,009	(1,050)	1,933,959			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,659,994	989,018	4,168,773	8,817,785		8,817,785	(91,051)	8,726,734			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: 01/01/2018 Ending: 12/31/2018

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	(18,508)	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	(7,600)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(1,430)	21		18
19	Entertainment	(662)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(145)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(31,837)	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	(6,330)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,675)		$	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)	(23,376)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (23,376)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (91,051)		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (2,749)	20	1
2	To Offset Medical Records Income	(1,129)	10	2
3	To Eliminate Lobbying & PAC Dues	(3,281)	20	3
4	To Record Full Year IDPH License Fee	829	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**	(6,330)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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	(18,508)	741	0	0	0	0	0	0	0	0	0	(17,767)	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**	(18,571)	741	0	0	0	0	0	0	0	0	0	(17,830)	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	(1,129)	25,203	0	0	0	0	0	0	0	0	0	24,074	10
10a	Therapy	0	0	723	0	0	0	0	0	0	0	0	723	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**	(1,129)	25,203	723	0	0	0	0	0	0	0	0	24,797	16
	C. General Administration													
17	Administrative	0	(323,632)	142	0	0	0	0	0	0	0	0	(323,490)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(145)	21,766	0	0	0	0	0	0	0	0	0	21,621	19
20	Fees, Subscriptions & Promotions	(38,138)	1,667	0	0	0	0	0	0	0	0	0	(36,471)	20
21	Clerical & General Office Expenses	(2,092)	196,931	12	0	0	0	0	0	0	0	0	194,851	21
22	Employee Benefits & Payroll Taxes	0	23,987	119	0	0	0	0	0	0	0	0	24,106	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,025	8	0	0	0	0	0	0	0	0	7,033	24
25	Other Admin. Staff Transportation	0	8,140	15	0	0	0	0	0	0	0	0	8,155	25
26	Insurance-Prop.Liab.Malpractice	0	1,438	0	0	0	0	0	0	0	0	0	1,438	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(40,375)	(62,678)	296	0	0	0	0	0	0	0	0	(102,757)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,075)	(36,734)	1,019	0	0	0	0	0	0	0	0	(95,790)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,017	0	0	0	0	0	0	0	0	0	2,017	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,600)	0	11	0	0	0	0	0	0	0	0	(7,589)	32
33	Real Estate Taxes	0	71	0	0	0	0	0	0	0	0	0	71	33
34	Rent-Facility & Grounds	0	10,345	0	0	0	0	0	0	0	0	0	10,345	34
35	Rent-Equipment & Vehicles	0	0	945	0	0	0	0	0	0	0	0	945	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,600)	12,433	956	0	0	0	0	0	0	0	0	5,789	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	(1,050)	0	0	0	0	0	0	0	0	(1,050)	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	(1,050)	0	0	0	0	0	0	0	0	(1,050)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,675)	(24,301)	925	0	0	0	0	0	0	0	0	(91,051)	45

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Serv.	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 Olney	Olney, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 741	$ 741	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	25,203	25,203	2
3	V	17	Management Fees	351,800	Bridgemark Healthcare, LLC	100.00%	28,168	(323,632)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	21,766	21,766	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,667	1,667	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	196,931	196,931	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	23,987	23,987	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,025	7,025	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	8,140	8,140	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,438	1,438	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,017	2,017	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	71	71	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	10,345	10,345	13
14	Total			$ 351,800			$ 327,499	$ * (24,301)	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: 01/01/2018 Ending: 12/31/2018

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%	$ 945	$ 945	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V	10a	Therapy		NW Rehab, LLC	100.00%	723	723	22
23	V	17	Admin Salaries		NW Rehab, LLC	100.00%	142	142	23
24	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	12	12	24
25	V	22	Employee Benefits		NW Rehab, LLC	100.00%	119	119	25
26	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	8	8	26
27	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	15	15	27
28	V	32	Interest		NW Rehab, LLC	100.00%	11	11	28
29	V	39	Ancillary Services	1,050	NW Rehab, LLC	100.00%		(1,050)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,050			$ 1,975	$ * 925	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: 01/01/2018 Ending: 12/31/2018

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	Adminstrative	100.00	271,832	4.69	9.39	Distribution	$ 28,168	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	$ 28,168		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: 01/01/2018 Ending: 12/31/2018

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			Helia Healthcare of Effingham	Effingham, IL				6
7			Helia Healthcare of Salem	Salem, IL				7
8			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				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: 01/01/2018 Ending: 2/31/2018

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	380,780	15	$ 7,897	$	35,753	$ 741	1
2	10	Nursing & Medical Supplies	Resident Days	380,780	15	268,418	268,418	35,753	25,203	2
3	17	Owner's Compensation	Resident Days	380,780	15	300,000		35,753	28,168	3
4	19	Professional Fees	Resident Days	380,780	15	231,817		35,753	21,766	4
5	20	Dues, Subscriptions	Resident Days	380,780	15	17,755		35,753	1,667	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	35,753	169,030	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		35,753	27,901	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	380,780	15	255,471		35,753	23,987	8
9	24	Seminars	Resident Days	380,780	15	74,815		35,753	7,025	9
10	25	Admin Staff Travel	Resident Days	380,780	15	86,690		35,753	8,140	10
11	26	Insurance	Resident Days	380,780	15	15,316		35,753	1,438	11
12	30	Depreciation	Resident Days	380,780	15	21,481		35,753	2,017	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		35,753	71	13
14	34	Building Rent	Resident Days	380,780	15	102,060		35,753	9,583	14
15	34	Rental - Storage Unit	Resident Days	380,780	15	8,118		35,753	762	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		35,753	945	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,498,033	$ 2,068,642		$ 328,444	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	Nursing & Med	Revenue	2,717,752	19	792		1,050		2
3	10a	Therapy	Revenue	2,717,752	19	1,870,778	1,870,778	1,050	723	3
4	17	Admin Salaries	Revenue	2,717,752	19	366,622	366,622	1,050	142	4
5	20	Dues & Subscriptions	Revenue	2,717,752	19	41		1,050		5
6	21	Clerical & Office Supplies	Revenue	2,717,752	19	30,294		1,050	12	6
7	22	Employee Benefits	Revenue	2,717,752	19	308,794		1,050	119	7
8	24	Travel & Seminar	Revenue	2,717,752	19	19,790		1,050	8	8
9	25	Other Admin Transp	Revenue	2,717,752	19	37,856		1,050	15	9
10	32	Interest	Revenue	2,717,752	19	28,025		1,050	11	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					$ 2,662,992	$ 2,237,400		$ 1,030	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	129,597	6
7	Related Party Allocations										11	7
8												8
9	TOTAL Facility Related						$	$			$ 129,608	9
	B. Non-Facility Related*											
10	Interest Income Offset										(7,600)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,600)	14
15	TOTALS (line 9+line14)						$	$			$ 122,008	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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	82,323	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.)	$	108,928	2
3. Under or (over) accrual (line 2 minus line 1).	$	26,605	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,800	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.	$	81,405	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	65,600	8
	2014	66,773	9
	2015	69,034	10
	2016	82,323	11
	2017	81,405	12

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

81,405 Line 7, Real Estate Portion of Lease Payments
71 Bridgemark Healthcare Allocation
81,476 Total Schedule V, Line 33

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

2017 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 2017 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 2017.

	(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	$ 579.16	$ 579.16
2.	08-28.0-403-056	LOT/SEC-58PT LOTS 57 & 58	$ 5,404.62	$ 5,404.62
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	$ 53.78	$ 53.78
5.	08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	$ 110.22	$ 110.22
6.	08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	$ 355.84	$ 355.84
7.	08-28.0-403-055	LOT/SEC-58 PT LTS 57 & 58	$ 74,901.34	$ 74,901.34
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,404.96	$ 81,404.96

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

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 Deoartment Connection			2008	1,685	126	10	126		1,685	9
10	Metro Lock & Security & Fire Alarm Door Holders			2009	2,614	214	10	214		2,076	10
11	Water Heater			2009	3,443	344	10	344		3,385	11
12	Kitchen Floor			2009	1,799	180	10	180		1,754	12
13	New Compressor			2009	1,647	110	15	110		1,034	13
14	Commercial Disposal			2010	1,272		5			1,272	14
15	P-Tec Heat Pump			2010	1,964	196	10	196		1,767	15
16	Replace Rooftop AC Unit			2010	4,481	448	10	448		3,996	16
17	2 Victorian Fire Doors			2011	2,500	167	15	167		1,208	17
18	22 Fire Doors			2011	6,688	446	15	446		3,232	18
19	Cabinets for New Therapy Room			2012	3,759	251	15	251		1,525	19
20	PTAC Unit			2012	956		5			956	20
21	5x5 PCS Gate			2012	630		5			630	21
22	Transformer, Power Supply			2012	2,202	220	10	220		1,468	22
23	Hot Water Storage Tank			2012	1,800	90	20	90		593	23
24	New Compressor & Rooftop Unit			2012	13,089	873	15	873		5,672	24
25	100 Gallon Natural Gas water heater			2012	3,197	320	10	320		1,945	25
26	4 PTAC Heat Pumps			2012	2,601		5			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, boarders labor										28
29	(cont.) doors, windows, electrical, lighting fixtures			2012	159,472	7,974	20	7,974		48,506	29
30	Power Metal Door			2012	5,530	277	20	277		1,682	30
31	Cabinets for New Med Room			2012	2,422	161	15	161		982	31
32	New Nurses' Station			2012	14,775	985	15	985		5,992	32
33	Relocated Fire Panel			2012	3,389	339	10	339		2,062	33
34	Build 2 new shower rooms - Tile, Fixtures, Walls, Labor			2012	17,907	895	20	895		5,447	34
35	Flooring for new ARCH Wing			2012	23,558	2,356	10	2,356		14,331	35
36	Building Sign			2013	8,449	845	10	845		4,788	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: 01/01/2018 Ending: 12/31/2018

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	$	$ 1,939	37
38	Carrier Heat Pump & Fan Coil	2013	7,236	724	10	724		3,799	38
39	Amana PTAC	2013	1,183	118	5	118		1,183	39
40	Replace Heat Exchanger	2014	1,902	380	5	380		1,902	40
41	Amana PTAC	2014	2,522	504	5	504		2,375	41
42	Cabling for New Call System	2014	1,330	266	5	266		1,285	42
43	Installation of annuciator panel for all wings	2014	4,438	444	10	444		2,125	43
44	Roof Repair	2014	12,880	1,288	10	1,288		5,692	44
45	500 Hall dining room drywall & paint	2014	1,715	171	10	171		729	45
46	Vinyl Plank Floor for 200 Hall	2015	3,485	348	10	348		1,220	46
47	Roof Repairs from Storm Damage	2017	3,500	350	10	350		613	47
48	Therapy Room Remodel - Cabinets, Vinyl Floor, Entryway Work	2018	6,823	76	15	76		76	48
49	PTAC Heat Pump, 9000 Cooling BTU	2018	1,414	165	5	165		165	49
50									50
51									51
52									52
53									53
54									54
55	Related Part Allocation - Bridgemark Healthcare								55
56	New Office Build Out	2011	12,752		20	675	675	5,033	56
57	Conference Rm Chair Rail & Paint	2012	144		5			144	57
58	AC Unit in Server Room	2018	989		20	25	25	25	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)		$ 359,274	$ 22,993		$ 23,693	$ 700	$ 148,894	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: 01/01/2018 Ending: 12/31/2018

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	$ 116,599	$ 10,618	$ 11,760	$ 1,142	3-15	$ 65,950	71
72	Current Year Purchases	10,787	320	495	175	3-15	495	72
73	Fully Depreciated Assets	46,969					46,969	73
74								74
75	TOTALS	$ 174,355	$ 10,938	$ 12,255	$ 1,317		$ 113,414	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	$ 1,875	$ 1,875	$	4	$ 3,125	76
77	2005 Chevy Truck		2017	7,164	1,791	1,791		4	2,985	77
78										78
79	Related Party Allocation - Bridgemark Healthcare			1,248					1,248	79
80	TOTALS			$ 15,912	$ 3,666	$ 3,666	$		$ 7,358	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)	$ 549,541	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,597	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,614	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,017	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 269,666	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: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Belleville Belt Property, 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	5/7/18	$ 674,272			3
4	Additions							4
5	Storage Rental							5
6	Related Party Allocations				10,345			6
7	TOTAL		156		$ 684,617 **			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 5/7/18
Ending 4/30/38

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 89,108 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

Helia Southbelt Healthcare
Attachment to Schedule XII B
Equipment Rentals
12/31/2018

	Description	
16A	Specialty Bed Rental	73,615
16B	Copier Lease	11,434
16C	Related Party Allocation - Bridgemark Healthcare	945
16D	Computer & Printer Rental	1,680
16E	Storage	1,434
		89,108

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				1,950		1,950	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				381,668		381,668	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					36,344		36,344	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				1,236,053			1,236,053	13
14	TOTAL			$		$ 1,236,053	$ 419,962		$ 1,656,015	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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,301	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (80,000))	1,473,707		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,412		6
7	Other Prepaid Expenses	2,452		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,489,872	$	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	345,388		15
16	Equipment, at Historical Cost	169,578		16
17	Accumulated Depreciation (book methods)	(247,391)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	54,800		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 322,375	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,812,247	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,983,051	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	358,682		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,540		31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,800		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	16,079		36
37	Due to Related Parties	3,165,330		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,597,482	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	63,967		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)**	$ 63,967	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,661,449	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,849,202)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,812,247	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,050,065)	1
2	Restatements (describe):		2
3	**Prior year A/R and R.E. tax adjustment**	(1,186,531)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,236,596)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(612,606)	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)**	$ (612,606)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,849,202)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 7,978,192	1
2	Discounts and Allowances for all Levels	(200,490)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,777,702	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	299,745	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 299,745	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***	7,600	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,600	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records	1,129	28
28a	Late Fee Forgiveness & Miscellaneous	119,003	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 120,132	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,205,179	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,174,835	31
32	Health Care	3,136,318	32
33	General Administration	1,560,589	33
	B. Capital Expense		
34	Ownership	1,011,034	34
	C. Ancillary Expense		
35	Special Cost Centers	1,655,115	35
36	Provider Participation Fee	279,894	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,817,785	40
41	**Income before Income Taxes (line 30 minus line 40)****	(612,606)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (612,606)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,150,167	44
45	Private Pay - Net Inpatient Revenue	395,090	45
46	Medicare - Net Inpatient Revenue	2,660,678	46
47	Other-(specify) Insurance	1,306,830	47
48	Other-(specify) Hospice	264,937	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,777,702	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: 01/01/2018 Ending: 12/31/2018

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	1,894	2,173	$ 96,528	$ 44.42	1
2	Assistant Director of Nursing	2,118	2,229	77,384	34.72	2
3	Registered Nurses	8,382	8,991	307,236	34.17	3
4	Licensed Practical Nurses	31,135	33,587	920,048	27.39	4
5	CNAs & Orderlies	72,763	78,532	1,107,053	14.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,412	4,848	76,714	15.82	10
11	Social Service Workers	5,110	5,575	118,886	21.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,616	20,391	239,859	11.76	15
16	Dishwashers					16
17	Maintenance Workers	3,365	3,820	85,815	22.46	17
18	Housekeepers	13,971	15,277	198,222	12.98	18
19	Laundry	5,599	6,296	73,838	11.73	19
20	Administrator	1,956	2,101	113,135	53.85	20
21	Assistant Administrator					21
22	Other Administrative	7,993	8,867	210,778	23.77	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	1,987	2,188	34,498	15.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,301	194,875	$ 3,659,994 *	$ 18.78	34

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		$ 25,523	1,3	35
36	Medical Director		72,956	9,3	36
37	Medical Records Consultant		2,213	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,268	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		7,628	11,3	44
45	Social Service Consultant		2,705	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 120,293		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 394	10,3	50
51	Licensed Practical Nurses	105	4,058	10,3	51
52	Certified Nurse Assistants/Aides	1,415	31,479	10,3	52
53	TOTAL (lines 50 - 52)	1,528	$ 35,931		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephanie Birch	Administrator	0	$ 113,135
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,135

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fee	$ 351,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 351,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 2,175
Personnel Planners	Unemployment Consultant	2,493
Mogan, Cohen, and Bach	Legal Fees	293
Leydiglaw	Legal Fees	10,325
Much Shelist	Legal Fees	220
Kramer & Frank, P.C.	Collections - Eliminated	145
Stein Law Offices	Legal Fees	1,445
Heyl, Royster, Voelker, & Allen, P.C.	Legal Fees	1,147
Paycom Payroll	Payroll Processing	24,547
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 42,790

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,315
Unemployment Compensation Insurance	45,683
FICA Taxes	276,990
Employee Health Insurance	49,025
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	7,633
Employee Benefits	6,519
Other Employee Insurance	1,066
Related Party Allocation - Bridgemark	23,987
Related Party Allocation - NW Rehab	119
TOTAL (agree to Schedule V, line 22, col.8)	$ 466,337

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	4,518
Health Care Worker Background Check	5,674
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	14,555
Miscellaneous Licenses & Fees	
Advertising	31,837
Related Party Allocation - Bridgemark	1,667
Less: Public Relations Expense	( )
Non-allowable advertising	(31,837)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,404

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,214
Seminar Expense	710
Related Party Allocation - Bridgemark	7,025
Related Party Allocation - NW Rehab	8
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,957

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 $7,015**

(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. $ **34,315** 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. $ **279,894**
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