

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0048587</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Helia Southbelt Healthcare</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> 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.	
Address: <u>101 South Belt West</u> <u>Belleville</u> <u>62220</u>			
NumberCityZip Code			
County: <u>St. Clair</u>			
Telephone Number: <u>(618) 277-7700</u> Fax # <u>(618) 355-4050</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>10/02/08</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>		(Signed) _____ (Date) _____ (Type or Print Name) <u>Michael Parentin</u> (Title) <u>Chief Financial Officer</u> (Signed) <u>See Accountant's Compilation Report</u> (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
Email Address: _____		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	272,740	18,901	11,105	302,746		302,746		302,746			1
2	Food Purchase		227,761		227,761		227,761	(219)	227,542			2
3	Housekeeping	177,409	40,030		217,439		217,439		217,439			3
4	Laundry	89,056	31,092		120,148		120,148		120,148			4
5	Heat and Other Utilities			126,631	126,631		126,631	602	127,233			5
6	Maintenance	80,722	24,438	61,510	166,670		166,670		166,670			6
7	Other (specify):*											7
8	TOTAL General Services	619,927	342,222	199,246	1,161,395		1,161,395	383	1,161,778			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,405,500	161,511		2,567,011		2,567,011	22,790	2,589,801			10
10a	Therapy		1,564		1,564		1,564		1,564			10a
11	Activities	89,824	17,858	8,389	116,071		116,071		116,071			11
12	Social Services	35,204		2,361	37,565		37,565		37,565			12
13	CNA Training											13
14	Program Transportation			9,215	9,215		9,215		9,215			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,530,528	180,933	27,165	2,738,626		2,738,626	22,790	2,761,416			16
	C. General Administration											
17	Administrative	84,024		395,860	479,884		479,884	(335,626)	144,258			17
18	Directors Fees											18
19	Professional Services			22,664	22,664		22,664	14,551	37,215			19
20	Dues, Fees, Subscriptions & Promotions			44,941	44,941		44,941	(26,792)	18,149			20
21	Clerical & General Office Expenses	175,181	27,876	64,978	268,035		268,035	251,691	519,726			21
22	Employee Benefits & Payroll Taxes			633,195	633,195		633,195	46,397	679,592			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,600	1,600		1,600	857	2,457			24
25	Other Admin. Staff Transportation			4,664	4,664		4,664	20,793	25,457			25
26	Insurance-Prop.Liab.Malpractice			69,511	69,511		69,511	1,681	71,192			26
27	Other (specify):*											27
28	TOTAL General Administration	259,205	27,876	1,237,413	1,524,494		1,524,494	(26,448)	1,498,046			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,409,660	551,031	1,463,824	5,424,515		5,424,515	(3,275)	5,421,240			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			6,908	6,908		6,908	7,478	14,386			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,451	53,451		53,451	(14)	53,437			32
33	Real Estate Taxes			73,476	73,476		73,476	79	73,555			33
34	Rent-Facility & Grounds			750,455	750,455		750,455	15,691	766,146			34
35	Rent-Equipment & Vehicles			51,196	51,196		51,196	469	51,665			35
36	Other (specify):*											36
37	TOTAL Ownership			935,486	935,486		935,486	23,703	959,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		246,280	926,318	1,172,598		1,172,598		1,172,598			39
40	Barber and Beauty Shops	27,047			27,047		27,047		27,047			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	27,047	246,280	1,011,728	1,285,055		1,285,055		1,285,055			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,436,707	797,311	3,411,038	7,645,056		7,645,056	20,428	7,665,484			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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				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	(14)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(219)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,790)	21		18
19	Entertainment	(1,990)	21		19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(446)	21		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,567)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(17,933)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,059)		\$	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)	67,487	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 67,487		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 20,428		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

Report Period Beginning:

Ending:

ID#

0048587

01/01/11

12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Eliminate Gifts & Flowers	\$ (12,588)	20	1
2	Offset Medical Records Income	(1,551)	10	2
3	Eliminate Lobbying & PAC Dues	(3,794)	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	(17,933)		49

Summary A

12/31/11

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

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint. Ser
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical Supply	St. Louis, MO	Medical Supplies
		Helia Healthcare of Energy	Energy, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			
		Helia Healthcare of Greenville	Greenville, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 602	\$ 602	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	24,341	24,341	2
3	V	17	Administrative	395,860	Bridgemark Healthcare, LLC	100.00%	60,234	(335,626)	3
4	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	14,551	14,551	4
5	V	20	Dues, Fees, & Subscriptions		Bridgemark Healthcare, LLC	100.00%	5,157	5,157	5
6	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	265,017	265,017	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	46,397	46,397	7
8	V	24	Travel & Seminars		Bridgemark Healthcare, LLC	100.00%	857	857	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	20,793	20,793	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,681	1,681	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	7,478	7,478	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	79	79	12
13	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	15,691	15,691	13
14	Total			\$ 395,860			\$ 462,878	\$ * 67,018	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 469	\$ 469	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 469	\$ * 469	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			Helia Healthcare of Olney	Olney, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3			Helia Healthcare of Rolla	Rolla, MO				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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	314,766	8	16.06	Distribution	\$ 60,234	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	\$ 60,234		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	294,279	12	\$ 3,751	\$	47,268	\$ 602	1
2	10	Nursing & Medical Records	Resident Days	294,279	12	151,540	151,540	47,268	24,341	2
3	17	Owner's Compensation	Resident Days	294,279	12	375,000		47,268	60,234	3
4	19	Profesional Fees	Resident Days	294,279	12	90,588		47,268	14,551	4
5	20	Dues, Subscriptions, & Fees	Resident Days	294,279	12	32,105		47,268	5,157	5
6	21	Salaries - Other	Resident Days	294,279	12	1,135,681	1,135,681	47,268	182,417	6
7	21	Clerical & Office Supplies	Resident Days	294,279	12	514,247		47,268	82,600	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	294,279	12	288,855		47,268	46,397	8
9	24	Seminars	Resident Days	294,279	12	5,335		47,268	857	9
10	25	Admin Staff Travel	Resident Days	294,279	12	129,453		47,268	20,793	10
11	26	Insurance	Resident Days	294,279	12	10,464		47,268	1,681	11
12	30	Depreciation	Resident Days	294,279	12	46,555		47,268	7,478	12
13	33	Real Estate Taxes	Resident Days	294,279	12	492		47,268	79	13
14	34	Building Rent	Resident Days	294,279	12	94,784		47,268	15,224	14
15	34	Rental - Storage Unit	Resident Days	294,279	12	2,905		47,268	467	15
16	35	Equipment Rental	Resident Days	294,279	12	2,920		47,268	469	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,884,675	\$ 1,287,221		\$ 463,347	25

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	53,451	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 53,451	9	
	B. Non-Facility Related*												
10	Interest Income		X								(14)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (14)	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 53,437	15	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.)				\$ (36,421)	2
3. Under or (over) accrual (line 2 minus line 1).				\$ (36,421)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$ 109,897	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.				\$ 73,476	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	109,897	8		
	2007	114,076	9		
	2008	119,380	10		
	2009	125,766	11		
	2010	117,905	12		
73,476 Line 7					
79 Bridgemark Healthcare Allocation					
73,555 Total Sxhedule V, Line 33					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Helia Southbelt Healthcare</u>	COUNTY	<u>St. Clair</u>
FACILITY IDPH LICENSE NUMBER	<u>0048587</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Michael Parentin</u>		
TELEPHONE	<u>(314) 431-0511</u>	FAX #:	<u>(314) 754-9176</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.

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.

☒ (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?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Fire Department Connection			2008	1,685	168	10	168		546
10	Metro Lock & Security & Fire Alarm Door Holders			2009	2,614	215	10	215		578
11	Water Heater			2009	3,443	344	10	344		975
12	Kitchen Floor			2009	1,799	180	10	180		495
13	New Compressor			2009	1,647	110	15	110		266
14	Commercial Disposal			2010	1,272	254	5	254		508
15	P-Tec Heat Pump			2010	1,964	196	10	196		392
16	Replace Rooftop AC Unit			2010	4,481	448	10	448		859
17	2 Victorian Fire Doors			2011	2,500	42	15	42		42
18	22 Fire Doors			2011	6,688	111	15	111		111
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

*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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Related Party Allocation - Bridgemark		\$	\$		\$	\$	\$	37
38	New Office Build-Out	2011	21,815		20	525	525	525	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 49,908	\$ 2,068		\$ 2,593	\$ 525	\$ 5,297	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 44,210	\$ 4,035	\$ 8,545	\$ 4,510	3-20	\$ 16,574	71
72	Current Year Purchases	41,265	805	2,423	1,618	3-20	2,423	72
73	Fully Depreciated Assets	90					90	73
74								74
75	TOTALS	\$ 85,565	\$ 4,840	\$ 10,968	\$ 6,128		\$ 19,087	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Related Party Allocation - Bridgemark			\$ 2,135	\$	\$ 825	\$ 825	4	\$ 1,377
77									
78									
79									
80	TOTALS			\$ 2,135	\$	\$ 825	\$ 825		\$ 1,377

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 137,608
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 6,908
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 14,386
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 7,478
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 25,761

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Section N/A	\$
93		
94		
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.

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?

☒ YES

☐ NO
- If NO, see instructions.

		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	\$ 749,443			3
4	Additions							4
5	Storage Rental				1,012			5
6	Related Party Allocation - Bridgemark				15,691			6
7	TOTAL		156		\$ 766,146			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

N/A

N/A

9. Option to Buy:

☐ YES

☒ NO

Terms: *

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

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO
16. Rental Amount for movable equipment: \$ 51,665Description: 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

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.	12/31/2012	\$ 766,179
13.	12/31/2013	\$ 789,165
14.	12/31/2014	\$ 806,921

* 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.

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

☒ 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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	10a, 2	hrs	\$		\$	55		\$	55	1		
2	Licensed Speech and Language Development Therapist		hrs								2		
3	Licensed Recreational Therapist		hrs								3		
4	Licensed Physical Therapist	10a, 2	hrs				1,509			1,509	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				232,177			232,177	9		
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)												
10			hrs								10		
11	Academic Education		hrs								11		
12	Other (specify): <u>Wound, Supplies</u>	39, 2					14,103			14,103	12		
	Physical, Occupational, & Speech Ther												
13	Other (specify): <u>X-Rays & Labs</u>	39, 3					926,318			926,318	13		
14	TOTAL			\$		\$	926,318	\$	247,844		\$	1,174,162	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,345	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 181,623)	1,664,272		3
4	Supply Inventory (priced at)	11,960		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,928		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	171,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,852,505	\$	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	28,092		15
16	Equipment, at Historical Cost	56,572		16
17	Accumulated Depreciation (book methods)	(15,785)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	238,451		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	82,946		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 390,276	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,242,781	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 906,442	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,908		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,665		31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,897		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Management Co.	1,423,455		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,641,367	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,641,367	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (398,586)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,242,781	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (543,677)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (543,677)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,091	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 145,091	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)	\$ (398,586)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,612,022	1
2	Discounts and Allowances for all Levels	(130,995)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,481,027	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	286,734	6
7	Oxygen	11,560	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 298,294	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	8,652	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)	\$ 8,652	23
	D. Non-Operating Revenue		
24	Contributions	512	24
25	Interest and Other Investment Income***	14	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 526	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	97	28
28a	Medical Record Copies	1,551	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,648	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,790,147	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,161,395	31
32	Health Care	2,738,626	32
33	General Administration	1,524,494	33
	B. Capital Expense		
34	Ownership	935,486	34
	C. Ancillary Expense		
35	Special Cost Centers	1,199,645	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,645,056	40
41	Income before Income Taxes (line 30 minus line 40)**	145,091	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 145,091	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 75,302	\$ 36.20	1
2	Assistant Director of Nursing	1,920	2,028	64,674	31.89	2
3	Registered Nurses	6,585	6,896	184,341	26.73	3
4	Licensed Practical Nurses	38,836	40,622	963,856	23.73	4
5	CNAs & Orderlies	91,790	98,821	1,056,823	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,501	5,952	60,504	10.17	8
9	Activity Director					9
10	Activity Assistants	7,006	7,311	89,824	12.29	10
11	Social Service Workers	2,126	2,401	35,204	14.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,853	27,178	272,740	10.04	15
16	Dishwashers					16
17	Maintenance Workers	4,557	5,113	80,722	15.79	17
18	Housekeepers	15,088	17,211	177,409	10.31	18
19	Laundry	9,132	10,159	89,056	8.77	19
20	Administrator	2,040	2,040	84,024	41.19	20
21	Assistant Administrator					21
22	Other Administrative	7,870	8,400	128,107	15.25	22
23	Office Manager	2,008	2,160	47,074	21.79	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beautician	1,801	2,020	27,047	13.39	33
34	TOTAL (lines 1 - 33)	223,193	240,392	\$ 3,436,707 *	\$ 14.30	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 11,105	1, 3	35
36	Medical Director		7,200	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		8,389	11, 3	44
45	Social Service Consultant		2,361	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,055		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$5,566

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

3-20 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$

19,253

 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. \$

85,410

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.

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

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$

N/A

 Has any meal income been offset against related costs?

No

 Indicate the amount. \$

N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

 If YES, please indicate the amount of income earned from such a program during this reporting period. \$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$

N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

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

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Southbelt Healthcare
Attachment to Schedule XII B
Equipment Rentals
12/31/2011

Description		
16A	Nursing Equipment Rental	\$ 36,992
16B	Copier Lease	13,012
16C	Dietary Equipment Rental	1,192
16D	Related Party Allocation - Bridgemark	469
		<u>\$ 51,665</u>