



Facility Name & ID Number Helia Southbelt Healthcare

# 0048587 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	28,411	9,262	10,494	48,167	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,411	9,262	10,494	48,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.59%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

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  Date 10/02/08 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 156 and days of care provided 6,677

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 1/1/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	268,429	23,765	630	292,824		292,824		292,824		1
2	Food Purchase		221,382		221,382		221,382	(298)	221,084		2
3	Housekeeping	156,954	48,098		205,052		205,052		205,052		3
4	Laundry	79,040	17,606		96,646		96,646		96,646		4
5	Heat and Other Utilities			121,716	121,716		121,716	178	121,894		5
6	Maintenance	71,612	16,710	48,200	136,522		136,522		136,522		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	576,035	327,561	170,546	1,074,142		1,074,142	(120)	1,074,022		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,370,058	184,782	76,677	2,631,517		2,631,517	33,550	2,665,067		10
10a	Therapy		2,399	937,130	939,529		939,529		939,529		10a
11	Activities	73,015	20,632	10,993	104,640		104,640	(13,923)	90,717		11
12	Social Services	58,939	127	15,703	74,769		74,769		74,769		12
13	CNA Training										13
14	Program Transportation			176	176		176		176		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,502,012	207,940	1,047,879	3,757,831		3,757,831	19,627	3,777,458		16
	<b>C. General Administration</b>										
17	Administrative	81,006		401,214	482,220		482,220	(316,523)	165,697		17
18	Directors Fees										18
19	Professional Services			20,581	20,581		20,581	9,554	30,135		19
20	Dues, Fees, Subscriptions & Promotions			68,960	68,960		68,960	(47,277)	21,683		20
21	Clerical & General Office Expenses	214,665	26,853	54,486	296,004		296,004	122,170	418,174		21
22	Employee Benefits & Payroll Taxes			549,569	549,569		549,569	45,551	595,120		22
23	Inservice Training & Education					34	34		34		23
24	Travel and Seminar			2,982	2,982	(34)	2,948	1,254	4,202		24
25	Other Admin. Staff Transportation			7,860	7,860		7,860	21,718	29,578		25
26	Insurance-Prop.Liab.Malpractice			119,252	119,252		119,252	1,481	120,733		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	295,671	26,853	1,224,904	1,547,428		1,547,428	(162,072)	1,385,356		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,373,718	562,354	2,443,329	6,379,401		6,379,401	(142,565)	6,236,836		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			2,996	2,996		2,996	3,309	6,305		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			101,773	101,773		101,773	(3,936)	97,837		32
33	Real Estate Taxes			109,897	109,897		109,897	622	110,519		33
34	Rent-Facility & Grounds			702,031	702,031		702,031	15,409	717,440		34
35	Rent-Equipment & Vehicles			23,426	23,426		23,426	492	23,918		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			940,123	940,123		940,123	15,896	956,019		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		214,296	23,698	237,994		237,994		237,994		39
40	Barber and Beauty Shops	28,545			28,545		28,545		28,545		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	<b>TOTAL Special Cost Centers</b>	28,545	214,296	109,108	351,949		351,949		351,949		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,402,263	776,650	3,492,560	7,671,473		7,671,473	(126,669)	7,544,804		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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,923)	11		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	(3,936)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(298)	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	(1,078)	21		18
19	Entertainment	(5,362)	21		19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(36)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,583)	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	(78,809)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (123,525)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(3,144)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (3,144)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (126,669)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

**Helia Southbelt Healthcare**

ID# 0048587

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To eliminate gifts & flowers	\$ (27,428)	20	1
2	To eliminate marketing salaries	(49,219)	21	2
3	To eliminate fees associated with collections	(1,236)	21	3
4	To offset medical records income	(177)	10	4
5	To eliminate PAC Dues	(749)	20	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	<b>Total</b>	(78,809)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Southbelt Healthcare# 0048587

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(298)	0	0	0	0	0	0	0	0	0	0	(298)	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	0	178	0	0	0	0	0	0	0	0	0	178	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	<b>TOTAL General Services</b>	<b>(298)</b>	<b>178</b>	<b>0</b>	<b>(120)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(177)	33,727	0	0	0	0	0	0	0	0	0	33,550	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13,923)	0	0	0	0	0	0	0	0	0	0	(13,923)	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	<b>TOTAL Health Care and Programs</b>	<b>(14,100)</b>	<b>33,727</b>	<b>0</b>	<b>19,627</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(316,523)	0	0	0	0	0	0	0	0	0	(316,523)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(36)	9,590	0	0	0	0	0	0	0	0	0	9,554	19
20	Fees, Subscriptions & Promotions	(47,760)	483	0	0	0	0	0	0	0	0	0	(47,277)	20
21	Clerical & General Office Expenses	(57,395)	179,565	0	0	0	0	0	0	0	0	0	122,170	21
22	Employee Benefits & Payroll Taxes	0	45,551	0	0	0	0	0	0	0	0	0	45,551	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,254	0	0	0	0	0	0	0	0	0	1,254	24
25	Other Admin. Staff Transportation	0	21,718	0	0	0	0	0	0	0	0	0	21,718	25
26	Insurance-Prop.Liab.Malpractice	0	1,481	0	0	0	0	0	0	0	0	0	1,481	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(105,191)</b>	<b>(56,881)</b>	<b>0</b>	<b>(162,072)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(119,589)</b>	<b>(22,976)</b>	<b>0</b>	<b>(142,565)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Southbelt Healthcare# 0048587

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	0	3,309	0	0	0	0	0	0	0	0	0	3,309	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,936)	0	0	0	0	0	0	0	0	0	0	(3,936)	32
33	Real Estate Taxes	0	0	622	0	0	0	0	0	0	0	0	622	33
34	Rent-Facility & Grounds	0	15,409	0	0	0	0	0	0	0	0	0	15,409	34
35	Rent-Equipment & Vehicles	0	492	0	0	0	0	0	0	0	0	0	492	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,936)</b>	<b>19,210</b>	<b>622</b>	<b>0</b>	<b>15,896</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(123,525)	(3,766)	622	0	0	0	0	0	0	0	0	(126,669)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	See Attached		Bridgemark Healthcare	St. Louis	Management Co.
				Bridgemark Employer Services	St. Louis	Human Resources
				Bridgemark Medical Supply	St. Louis	Medical Supplies
				Helia Healthcare Servicess	Benton	Lndry, Maint Serv

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%	\$ 178	\$	178	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	33,727		33,727	2
3	V	17 Management Fees	401,214	Bridgemark Healthcare, LLC	100.00%	84,691		(316,523)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	9,590		9,590	4
5	V	20 dues, Subscriptions, & Fees		Bridgemark Healthcare, LLC	100.00%	483		483	5
6	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	179,565		179,565	6
7	V	22 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	45,551		45,551	7
8	V	24 Seminars		Bridgemark Healthcare, LLC	100.00%	1,254		1,254	8
9	V	25 Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	21,718		21,718	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,481		1,481	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	3,309		3,309	11
12	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	15,409		15,409	12
13	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	492		492	13
14	Total		\$ 401,214			\$ 397,448	\$ *	(3,766)	14

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

**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	33 Real Estate Taxes	\$	Bridgemark Healthcare, LLC	100.00%	\$ 622	\$	622	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	<b>Total</b>		\$			\$ 622	\$ *	622	39

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

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	395,309	9	17.64	Distribution	\$ 84,691	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	\$ 84,691		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:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	272,995	11	\$ 1,007	\$ 48,167	\$ 178	1
2	10	Nursing & Medical Records	Resident Days	272,995	11	191,151	48,167	33,727	2
3	17	Management Fees	Resident Days	272,995	11	480,000	48,167	84,691	3
4	19	Professional Services	Resident Days	272,995	11	54,354	48,167	9,590	4
5	20	Dues, Subscriptions, & Fees	Resident Days	272,995	11	2,735	48,167	483	5
6	21	Clerical	Resident Days	272,995	11	1,017,715	48,167	179,565	6
7	22	Employee Benefits	Resident Days	272,995	11	258,166	48,167	45,551	7
8	24	Seminars	Resident Days	272,995	11	7,110	48,167	1,254	8
9	25	Admin Staff Travel	Resident Days	272,995	11	123,093	48,167	21,718	9
10	26	Insurance	Resident Days	272,995	11	8,392	48,167	1,481	10
11	30	Depreciation	Resident Days	272,995	11	18,757	48,167	3,309	11
12	33	Real Estate Taxes	Resident Days	272,995	11	3,528	48,167	622	12
13	34	Building Rent	Resident Days	272,995	11	83,890	48,167	14,801	13
14	34	Rental - Storage Unit	Resident Days	272,995	11	3,444	48,167	608	14
15	35	Equipment Rental	Resident Days	272,995	11	2,787	48,167	492	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,256,129	\$ 1,043,875	\$ 398,070	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia Southbelt Healthcare

# 0048587

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6	Midwest Bank		X	Line of Credit		1/1/07		10/22/09		80,182	6								
7	MidCap Funding I, LLC		X	Line of Credit		10/22/09			Variable	21,591	7								
8											8								
9	<b>TOTAL Facility Related</b>									<b>101,773</b>	<b>9</b>								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(3,936)	10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>									<b>(3,936)</b>	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>									<b>97,837</b>	<b>15</b>								

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.)

Facility Name & ID Number **Helia Southbelt Healthcare**# **0048587**Report Period Beginning: **1/1/09**Ending: **12/31/09****12/31/09****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 report.		\$	<b>27,474</b>		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.)		\$	<b>119,380</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>91,906</b>		3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>17,991</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>109,897</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	<b>95,303</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2005	<b>102,528</b>	<b>9</b>	13	FROM R. E. TAX STATEMENT FOR 2008 \$
	2006	<b>109,897</b>	<b>10</b>	14	PLUS APPEAL COST FROM LINE 5 \$
	2007	<b>114,076</b>	<b>11</b>	15	LESS REFUND FROM LINE 6 \$
	2008	<b>119,380</b>	<b>12</b>	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>109,897</b> Line 7					
<b>622</b> Bridgemark Healthcare Allocation					
<b>110,519</b> 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' COMPILATION REPORT



Facility Name & ID Number Helia Southbelt Healthcare

# 0048587

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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				\$	\$		\$	\$	\$
5									
6									
7									
8									
	<b>Improvement Type**</b>								
9	Fire Department Connection	2008		1,685	169	10	169		211
10	Metro Lock & Security	2009		1,195	109	10	109		109
11	Water Heater	2009		3,443	287	10	287		287
12	Kitchen Floor	2009		1,799	135	10	135		135
13	New Compressor	2009		1,647	46	15	46		46
14	4 Fire Alarm Door Holders	2009		1,419	39	15	39		39
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare

# 0048587

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	37		
38								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)	\$	11,188	\$	785	\$	785	\$	827	70

SEE ACCOUNTANTS' COMPILATION 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:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 24,430	\$ 1,932	\$ 4,323	\$ 2,391	3-20 yrs	\$ 7,861	71
72	Current Year Purchases	19,900	279	535	256	3-20 yrs	535	72
73	Fully Depreciated Assets	99					99	73
74								74
75	TOTALS	\$ 44,429	\$ 2,211	\$ 4,858	\$ 2,647		\$ 8,495	75

D. Vehicle Depreciation (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	Bridgemark Healthcare Allcation			\$ 5,068	\$	\$ 662	\$ 662	4	\$ 1,946	76
77										77
78										78
79										79
80	TOTALS			\$ 5,068	\$	\$ 662	\$ 662		\$ 1,946	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)	\$ 60,685	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,996	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,305	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,309	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,268	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' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Four Fountains Aviv, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  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:	<u>156</u>	<u>4/1/08</u>	\$ <u>701,163</u>	<u>10</u>	<u>5</u>	3
4	Additions						4
5	Storage Rental			<u>868</u>			5
6	Related Party Bridgemark Allocation			<u>15,409</u>			6
7	TOTAL	<u>156</u>		\$ <u>717,440</u>			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

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: \$ 23,918 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

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. 12/31/2010 \$ 722,198

13. 12/31/2011 \$ 743,864

14. 12/31/2012 \$ 766,179

\* 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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a-3	hrs					\$ 407,172		\$ 909			\$ 408,081		1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs					102,883		232			103,115		2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	10a-3	hrs					427,075		1,258			428,333		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 prescripts							205,213			205,213		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify): <u>Lab &amp; X-Rays</u>	39-3						23,698					23,698		12	
13	Other (specify): <u>WoundCare,Supplies</u>	39-2								9,083			9,083		13	
14	TOTAL				\$			\$ 960,828		\$ 216,695			\$ 1,177,523		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

Facility Name & ID Number **Helia Southbelt Healthcare**# **0048587**Report Period Beginning: **1/1/09**Ending: **12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,425	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <b>81,407</b> )	<b>1,859,574</b>		3
4	Supply Inventory (priced at <b>Cost</b> )	<b>6,772</b>		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	<b>1,112</b>		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Deposits</b>	<b>171,000</b>		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,042,883	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>11,188</b>		15
16	Equipment, at Historical Cost	<b>28,562</b>		16
17	Accumulated Depreciation (book methods)	<b>(3,293)</b>		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	<b>216,150</b>		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 252,607	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,295,490	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,070,341	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	<b>204,897</b>		30
31	Accrued Taxes Payable (excluding real estate taxes)	<b>10,840</b>		31
32	Accrued Real Estate Taxes(Sch.IX-B)	<b>17,991</b>		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Due to Management Co</b>	<b>905,059</b>		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,209,128	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,209,128	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 86,362	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,295,490	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(99,362)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(99,362)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>185,724</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>185,724</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>86,362</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,599,256	1
2	Discounts and Allowances for all Levels	(193,924)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,405,332</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	425,050	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 425,050</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	13,923	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 13,923</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,495	24
25	Interest and Other Investment Income***	3,936	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 7,431</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Attached Schedule</u>	5,461	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,461</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,857,197</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,074,142	31
32	Health Care	3,757,831	32
33	General Administration	1,547,428	33
<b>B. Capital Expense</b>			
34	Ownership	940,123	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	266,539	35
36	Provider Participation Fee	85,410	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,671,473</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>185,724</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 185,724</b>	<b>43</b>

\* 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.

Facility Name & ID Number Helia Southbelt Healthcare

# 0048587

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	\$ 62,459	\$ 30.03	1
2	Assistant Director of Nursing	1,887	1,970	68,496	34.77	2
3	Registered Nurses	8,372	9,038	233,210	25.80	3
4	Licensed Practical Nurses	32,505	34,375	715,272	20.81	4
5	CNAs & Orderlies	93,543	97,179	1,104,635	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,792	4,060	46,650	11.49	8
9	Activity Director					9
10	Activity Assistants	6,951	7,229	73,015	10.10	10
11	Social Service Workers	4,049	4,215	58,939	13.98	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,083	42,464	20.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,473	24,750	225,965	9.13	15
16	Dishwashers					16
17	Maintenance Workers	4,029	4,290	71,612	16.69	17
18	Housekeepers	14,808	16,137	156,954	9.73	18
19	Laundry	8,857	9,345	79,040	8.46	19
20	Administrator	2,080	2,080	81,006	38.95	20
21	Assistant Administrator					21
22	Other Administrative	1,949	2,064	49,219	23.85	22
23	Office Manager	2,391	2,556	58,956	23.07	23
24	Clerical	7,565	8,186	106,490	13.01	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 C: Staff Coord.	2,016	2,080	50,360	24.21	32
33	Other(specify) CP/Tmt/Beaut.	6,052	6,329	117,521	18.57	33
34	TOTAL (lines 1 - 33)	228,415	240,046	\$ 3,402,263 *	\$ 14.17	34

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

\*\* See instructions.

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	30	\$ 630	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	12	488	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	5	180	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	196	10,993	11-03	44
45	Social Service Consultant	279	15,703	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	522	\$ 35,194		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5	\$ 262	10-03	50
51	Licensed Practical Nurses	1,098	40,004	10-03	51
52	Certified Nurse Assistants/Aides	1,648	35,743	10-03	52
53	TOTAL (lines 50 - 52)	2,751	\$ 76,009		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Helia Southbelt Healthcare**

# **0048587**

Report Period Beginning: **1/1/09**

Ending: **12/31/09**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tara Hamilton	Administrator	0.00	\$ 81,006	Workers' Compensation Insurance	\$ 117,365	IDPH License Fee	\$ 1,027	
				Unemployment Compensation Insurance	53,696	Advertising: Employee Recruitment	2,001	
				FICA Taxes	260,273	Health Care Worker Background Check		
				Employee Health Insurance	114,153	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	500	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,935	
				401(k) Match	4,082	Advertising	19,583	
				Bridgemark Healthcare Allocation	45,551	Bridgemark Healthcare Allocation	483	
						Late Fees	1,888	
						Misc. Fees & Licenses	849	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(19,583)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,006	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 595,120		\$ 21,683		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Bridgemark Healthcare LLC - Management Fees			\$ 401,214	N/A		\$	Out-of-State Travel	\$
							In-State Travel	840
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 401,214				Seminar Expense	2,108
							Bridgemark Healthcare Allocation	1,254
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V, line 24, col. 8)	
David C. Read Jr., CPA	Accounting Services	\$ 3,775		\$			TOTAL	
Ceridian	Payroll Processing	12,055					\$ 4,202	
Greensfelder, Hemker & Gale	Legal Fees	87						
Kramer & Frank	Collection Fees	36						
Ashman & Stein	Legal Fees	130						
Much Shelist	Legal Fees	2,413						
Kutak Rock, LLP	Legal Fees	2,085						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 20,581					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2006	6 FY2007	7 FY2008	8 FY2009	9 FY2010	10 FY2011	11 FY2012	12 FY2013	13 FY2014
1	Schedule N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Helia Southbelt Healthcare

# 0048587

Report Period Beginning:

1/1/09

Ending: 12/31/09

**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 \$8,611
- (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. \$ 46,182 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 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 VII A  
Related Nursing Homes  
12/31/2009

Helia Healthcare of Belleville  
Helia Healthcare of Benton  
Helia Healthcare of Carbondale  
Helia Healthcare of Champaign  
Helia Healthcare of Energy  
Frankfort Healthcare & Rehab Center  
Helia Healthcare of Greenville  
Helia Healthcare of Urbana  
Hillside Rehab & Care Center  
Helia Healthcare of Zion

Helia Southbelt Healthcare  
Attachment to Schedule XII B  
Equipment Rentals  
12/31/2009

<u>Description</u>			
16A	Specialty Bed Rental	\$	11,547
16B	Dietary Equipment Rental		964
16C	Copier Lease		10,915
16D	Related Party Allocation - Bridgemark		492
		<u>\$</u>	<u>23,918</u>

Helia Southbelt Healthcare  
Attachment to Schedule XVII  
Other Revenue  
12/31/2009

<u>Description</u>	
Medical Record Copies	\$ 177
Recovery of Bad Debt	4,873
Payroll Deduction for Physicals	360
Other Miscellaneous Income	51
	<u>\$ 5,461</u>

Helia Southbelt Healthcare  
Attachment to Schedule XX G.  
Seminar Detailed Description  
12/31/2009

<b>Name of Employee Attending</b>	<b>Job Title</b>	<b>Date</b>	<b>Location</b>	<b>Seminar Title</b>	<b>Seminar Sponsor</b>	<b>Seminar Cost</b>	<b>Travel Cost</b>
Susan Norhaus	DON	1/20/09	Belleville		IHCA	\$ 55.00	
Tara Hamilton, Joy Robers, & Joyce Kolassa	Administrator, SS, & SS	1/29/09-1/30/09	Belleville		Outcome Services	\$ 459.00	
Tara Hamilton & Susan Norhaus	Administrator & DON	3/4/09	Springfield	OBRA Pain Req.	IHCA	\$ 150.00	
Tara Hamilton	Administrator	3/6/09	Springfield		IHCA	\$ 95.00	\$ 221.76
Tara Hamilton	Administrator	4/29/09	Belleville		Pathways	\$ 99.00	
Tara Hamilton	Administrator	6/17/09	Belleville		IHCA	\$ 95.00	
Tara Hamilton	Administrator	6/19/09	Belleville		IHCA	\$ 95.00	\$ 219.52
Tara Hamilton & Susan Norhaus	Administrator & DON	7/14/09	Springfield		IHCA	\$ 190.00	
Tara Hamilton, Susan Norhaus, Bonnie Carrillon, & Renita Hall	Administrator, DON, ADON, & Care Plan Assistant	8/12/09	Effingham	HFA MDS	IHCA	\$ 380.00	
LeAnna Kaenmerer	Activities	9/23, 9/24, 9/30		Act. Dir. Course	Outcome Services	\$ 360.00	
Darlene Neumeyer	Activities	11/12/09		Act. Dir. Course	Outcome Services	\$ 130.00	
Miscellaneous Travel & Lodging							\$ 398.72
Related Party Allocation - Bridgemark						\$1,254.00	
						<u>\$3,362.00</u>	<u>\$ 840.00</u>
							\$4,202.00