

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0048827</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Helia Healthcare Belleville</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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>40 North 64th Street</u> <u>Belleville</u> <u>62223</u>																									
Number City Zip Code																									
County: <u>St Clair</u>																									
Telephone Number: <u>(618) 397-8400</u> Fax # <u>(618) 397-8470</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jason Mills</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td>(Signed) <u>See Accountant's Preparatoin Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E Center Drive, Alton, IL 62002</u></td></tr><tr><td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jason Mills</u>	(Title) <u>Chief Financial Officer</u>	(Signed) <u>See Accountant's Preparatoin Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E Center Drive, Alton, IL 62002</u>	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>												
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	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																								
Date of Initial License for Current Owners: <u>12/01/07</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville

0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	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	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,652</u>	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	<u>122</u>	TOTALS	<u>122</u>	<u>44,652</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,198</u>	<u>420</u>	<u>2,474</u>	<u>20,092</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,198</u>	<u>420</u>	<u>2,474</u>	<u>20,092</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.00 %

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

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 12/01/07

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/07 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 122 and days of care provided 1,972

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020
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	163,216	10,434	12,931	186,581		186,581		186,581			1
2	Food Purchase		122,913		122,913		122,913	(13)	122,900			2
3	Housekeeping	122,319	30,297	390	153,006		153,006		153,006			3
4	Laundry	41,828	25,600		67,428		67,428		67,428			4
5	Heat and Other Utilities			154,079	154,079		154,079	(18,139)	135,940			5
6	Maintenance	69,084	18,673	61,791	149,548		149,548		149,548			6
7	Other (specify):*											7
8	TOTAL General Services	396,447	207,917	229,191	833,555		833,555	(18,152)	815,403			8
	B. Health Care and Programs											
9	Medical Director			36,675	36,675		36,675		36,675			9
10	Nursing and Medical Records	1,423,123	181,360	511,485	2,115,968		2,115,968	20,064	2,136,032			10
10a	Therapy	683,032	121,612		804,644		804,644		804,644			10a
11	Activities	31,005	2,348	2,892	36,245		36,245	(450)	35,795			11
12	Social Services	49,197	96	2,577	51,870		51,870		51,870			12
13	CNA Training											13
14	Program Transportation			2,890	2,890		2,890		2,890			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,186,357	305,416	556,519	3,048,292		3,048,292	19,614	3,067,906			16
	C. General Administration											
17	Administrative	103,579		363,600	467,179		467,179	(343,448)	123,731			17
18	Directors Fees											18
19	Professional Services			72,116	72,116		72,116	6,543	78,659			19
20	Dues, Fees, Subscriptions & Promotions			47,056	47,056		47,056	(22,347)	24,709			20
21	Clerical & General Office Expenses	121,415	32,545	92,127	246,087		246,087	101,848	347,935			21
22	Employee Benefits & Payroll Taxes			299,051	299,051		299,051	11,701	310,752			22
23	Inservice Training & Education											23
24	Travel and Seminar			439	439		439	1,764	2,203			24
25	Other Admin. Staff Transportation			2,711	2,711		2,711	2,519	5,230			25
26	Insurance-Prop.Liab.Malpractice			306,580	306,580		306,580	16,966	323,546			26
27	Other (specify):*											27
28	TOTAL General Administration	224,994	32,545	1,183,680	1,441,219		1,441,219	(224,454)	1,216,765			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,807,798	545,878	1,969,390	5,323,066		5,323,066	(222,992)	5,100,074			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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			81,118	81,118		81,118	2,864	83,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,825	10,825		10,825	(5,622)	5,203			32
33	Real Estate Taxes			66,000	66,000		66,000	31	66,031			33
34	Rent-Facility & Grounds			788,472	788,472		788,472	5,297	793,769			34
35	Rent-Equipment & Vehicles			101,025	101,025		101,025	787	101,812			35
36	Other (specify):*											36
37	TOTAL Ownership			1,047,440	1,047,440		1,047,440	3,357	1,050,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		332,416	366,086	698,502		698,502		698,502			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,520	181,520		181,520		181,520			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		332,416	547,606	880,022		880,022		880,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,807,798	878,294	3,564,436	7,250,528		7,250,528	(219,635)	7,030,893			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(450)	11		4
5	Telephone, TV & Radio in Resident Rooms	(18,539)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,622)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	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	(550)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,087)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,204)	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	(7,953)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,418)		\$	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	2	
		Amount	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)	(167,217)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (167,217)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (219,635)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	\$ (2,661)	20	1
2	To Eliminate Lobbying/PAC Dues	(2,999)	20	2
3	To Offset Medical Record Inome	(2,293)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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36				36
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,953)		49

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
<u>Stephen P. Miller</u>	<u>100</u>	<u>Helia Healthcare of Benton</u>	<u>Benton, IL</u>	<u>Bridgemark Healthcar</u>	<u>St. Ann, MO</u>	<u>Management Co.</u>
		<u>Hillside Rehab & Care Center</u>	<u>Yorkville, IL</u>	<u>Helia Healthcare Servi</u>	<u>Benton, IL</u>	<u>Laundry Maint.</u>
		<u>Helia Healthcare of Energy</u>	<u>Energy, IL</u>	<u>Bridgemark Employer</u>	<u>St. Ann, MO</u>	<u>Human Resources</u>
		<u>Helia Healthcare of Olney</u>	<u>Olney, IL</u>	<u>Palladian Management</u>	<u>O'Fallon, IL</u>	<u>Management Co.</u>
		<u>Helia Southbelt Healthcare</u>	<u>Belleville, IL</u>	<u>Palladian Mt. Vernon</u>	<u>Mt. Vernon, IL</u>	<u>Assisted Living</u>
		<u>Frankfort Healthcare & Rehab Center</u>	<u>West Frankfort, IL</u>	<u>Palladian Taylorville A</u>	<u>Taylorville, IL</u>	<u>Assisted Living</u>
		<u>Helia Healthcare of Hillsboro</u>	<u>Hillsboro, IL</u>			

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	<u>Utilities</u>	\$	<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>\$ 400</u>	<u>\$ 400</u>	1
2	V	10	<u>Nursing & Medical Records</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>22,357</u>	<u>22,357</u>	2
3	V	17	<u>Management Fees</u>	<u>363,600</u>	<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>20,152</u>	<u>(343,448)</u>	3
4	V	19	<u>Professional Services</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>6,543</u>	<u>6,543</u>	4
5	V	20	<u>Dues, Subscriptions</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>1,067</u>	<u>1,067</u>	5
6	V	21	<u>Clerical & General Office</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>103,935</u>	<u>103,935</u>	6
7	V	22	<u>Employee Benefits & Payroll Taxes</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>11,701</u>	<u>11,701</u>	7
8	V	24	<u>Travel & Seminar</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>1,764</u>	<u>1,764</u>	8
9	V	25	<u>Admin Staff Transportation</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>2,519</u>	<u>2,519</u>	9
10	V	26	<u>Insurance</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>16,966</u>	<u>16,966</u>	10
11	V	30	<u>Depreciation</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>2,864</u>	<u>2,864</u>	11
12	V	33	<u>Real Estate Taxes</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>31</u>	<u>31</u>	12
13	V	34	<u>Rent</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>5,297</u>	<u>5,297</u>	13
14	Total			<u>\$ 363,600</u>			<u>\$ 195,596</u>	<u>\$ * (168,004)</u>	14

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

SEE ACCOUNTANTS' PREPARATION 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.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		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%	\$ 787	\$ 787	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			\$			\$ 787	\$ * 787	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Helia Healthcare Belleville

0048827

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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								1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Effingham	Effingham, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				7
8			Helia Richland Healthcare, LLC	Olney, IL				8
9			Helia Healthcare of Newton, LLC	Newton, IL				9
10			Palladian Aviston SNF, LLC	Aviston, IL				10
11			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				11
12			Palladian Taylorville SNF, LLC	Taylorville, IL				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	386,276	2.48	4.96	Distribution	\$ 20,152	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	\$ 20,152		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 IV Trust		X	Line of Credit		10/22/09					Var.	8,123	6
7	Omnicare		X	Vendor Note							7.5000	43	7
8	Medline		X	Vendor Note		11/15/19					8.0000	2,659	8
9	TOTAL Facility Related						\$					\$ 10,825	9
	B. Non-Facility Related*												
10	Interest Income Offset											(5,622)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (5,622)	14
15	TOTALS (line 9+line14)						\$					\$ 5,203	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

FACILITY NAME Helia Healthcare Belleville COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048827

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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:

B. General Construction Type:

Exterior Brick

Frame Brick

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.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville

0048827

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	Plasterers			2007	6,731	337	20	337		4,712	9	
10	Air Units			2007	1,215		10			1,215	10	
11	Supplies for Sign			2007	1,060		10			1,060	11	
12	Vanities			2008	810		10			810	12	
13	Windows			2008	1,065	53	20	53		657	13	
14	Sprinklers			2008	7,898	527	15	527		6,450	14	
15	Asphalt for Rear of Building			2008	2,085		8			2,085	15	
16	New Nurse's Station & Renovation of front entrance & hallways			2009	35,615	2,374	15	2,374		27,024	16	
17	Asphalt for Front of Building			2009	1,295		8			1,295	17	
18	Cabinets			2009	3,965	264	15	264		2,996	18	
19	Carpet			2009	9,553		5			9,553	19	
20	14 Doors			2009	4,382	292	15	292		3,262	20	
21	Wing Remodel - Carpet, hand rails, paint, nurses station, plumbing, door			2010	56,248	2,812	20	2,812		28,827	21	
22	Rooftop Heater & Compressor			2010	6,782	452	15	452		4,860	22	
23	Cabinets for Utility			2010	1,023	68	15	68		716	23	
24	Tile & Carpet			2010	4,793		5			4,793	24	
25	Countertops			2010	1,352	90	10	90		939	25	
26	Facility Signage			2010	3,292	274	10	274		3,292	26	
27	A/C Units			2011	6,876	688	10	688		6,819	27	
28	Shower Room - flooring, electric, shower heads, fixtures, paint			2011	9,427	629	15	629		5,708	28	
29	A/C Units			2011	6,675		5			6,675	29	
30	New Amp Meter			2012	595	60	10	60		516	30	
31	Replace security system keypad			2012	717	72	10	72		615	31	
32	HVAC System			2012	6,755	450	15	450		3,828	32	
33	Entrance Door			2012	2,397	160	15	160		1,305	33	
34	PTAC Units			2012	2,169	217	10	217		1,808	34	
35	Water Heater Booster			2012	1,448	145	10	145		1,195	35	
36	Frigidaire PTAC Units			2012	2,895	5				2,895	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' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville

0048827

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Radiator for Generator	2013	\$ 3,846	\$ 385	10	\$ 385	\$	\$ 2,660	37
38	Data Cabling & Wiring	2014	2,812	281	10	281		1,922	38
39	Hand Rail Lumber	2014	3,486	232	15	232		1,549	39
40	Nurses Station POC	2014	698		5			698	40
41	Room Signs	2014	1,694		5			1,694	41
42	Frigidaire Coor/Heater	2014	739		5			739	42
43	Alarm System	2014	2,350	235	10	235		1,488	43
44	3 Commodes	2014	828	83	10	83		517	44
45	3 New AC Untis	2014	1,901		5			1,901	45
46	5 PTAC Units	2015	3,000	150	5	150		3,000	46
47	Ventilatro Monitoring system and cameras	2015	6,645	997	15	997		6,645	47
48	Tile and Backling for front sitting area & therapy room	2015	8,279	828	10	828		4,209	48
49	Water Heater	2015	3,910	391	10	391		1,955	49
50	Dining Room Paint	2018	5,610	561	10	561		1,402	50
51	100 Gallon Water Heater	2018	7,531	753	10	753		1,632	51
52	Cabinets, Flooring, Sink, Counters in Therapy room	2019	5,585	372	15	372		652	52
53	Hot Water Heater	2019	7,531	753	15	753		1,318	53
54	Rework Plumbing System per IDPH	2019	11,224	561	10	561		795	54
55	Flooring 200 Hall & Dining Room	2019	8,294	829	10	829		1,106	55
56	New Windows throughout the facility	2019	60,136	3,007	20	3,007		3,633	56
57	Back Flow Preventer at ain water supply	2019	14,503	725	20	725		906	57
58	Roofing Membrane	2019	15,000	1,500	10	1,500		1,625	58
59	200 Hall Raskin Alpine Whisper LVP - Modern	2020	1,820	167	10	167		167	59
60	Hot Water Heater - Axis Plumbing	2020	9,485		10				60
61									61
62									62
63									63
64									64
65									65
66	Related Party Allocation - Bridgemark Healthacer, LLC								66
67	New Office Build Out	2011	6,734		20	357	357	3,371	67
68	Conference Rm Chair Rail & Paint	2012	76		20			76	68
69	AC Unit in Server Room	2018	522		20	26	26	65	69
70	TOTAL (lines 4 thru 69)		\$ 383,357	\$ 22,774		\$ 23,157	\$ 383	\$ 181,635	70

SEE ACCOUNTANTS' PREPARATION 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	\$ 457,014	\$ 51,097	\$ 53,247	\$ 2,150		\$ 301,378	71
72	Current Year Purchases	18,765	2,710	3,041	331		3,041	72
73	Fully Depreciated Assets	13,221					13,221	73
74								74
75	TOTALS	\$ 489,000	\$ 53,807	\$ 56,288	\$ 2,481		\$ 317,640	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	Facility	2002 Ford E-450	2010	\$ 4,000	\$	\$	\$	4	\$ 4,000	76
77	Facility	Van	2016	20,000	2,083	2,083		4	20,000	77
78	Facility	2007 Chevy Uplander Minivan w/	2020	11,780	2,454	2,454		4	2,454	78
79										79
80	TOTALS			\$ 35,780	\$ 4,537	\$ 4,537	\$		\$ 26,454	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)	\$ 908,137	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,982	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,864	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 525,729	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:OMG Belleville 64th Property, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ 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:		122		\$ 786,138			3
4	Additions							4
5	Related Party Allocations - Bridgemark Healthcare				5,297			5
6	Storage Rental				2,334			6
7	TOTAL		122		\$ 793,769			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 leaseN/A.
9. Option to Buy:☐ YES☒ X 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: \$ 101,812 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Belleville
Attachment to Schedule XII B
Equipment Rentals
12/31/2020

Description		
16A	Nursing Equipment Rental	30,551
16B	Respiratory Equipment	65,754
16C	Copier Lease	4,720
16D	Related Party Allocation - Bridgemark Healthcare	787
		<u>101,812</u>

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				46		46	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				217,815		217,815	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxygen, Enter</u>	39, 2					114,601		114,601	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3 & 10a, 2				366,086	121,566		487,652	13
14	TOTAL			\$		\$ 366,086	\$ 454,028		\$ 820,114	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 5,552	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,000))	916,821		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	553		7
8	Accounts Receivable (owners or related parties)	5,611,087		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,534,013	\$	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	363,458		15
16	Equipment, at Historical Cost	526,580		16
17	Accumulated Depreciation (book methods)	(512,562)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 377,476	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,911,489	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 406,399	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,556		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,548		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	10,466		36
37	Deferred CARES Funds	400,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 976,969	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	291,142		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)	\$ 291,142	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,268,111	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,643,378	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,911,489	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,330,467	1
2	Restatements (describe):		2
3	2019 Adjustments	(175)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,330,292	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	313,086	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)	\$ 313,086	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)	\$ 5,643,378	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville

0048827

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,071,110	1
2	Discounts and Allowances for all Levels	(284,557)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,786,553	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	188,534	6
7	Oxygen	14,351	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 202,885	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,622	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,622	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Medical Records/Miscellaneous</u>	20,004	28
28a	<u>CARES Funds</u>	548,550	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 568,554	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,563,614	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	833,555	31
32	Health Care	3,048,292	32
33	General Administration	1,441,219	33
	B. Capital Expense		
34	Ownership	1,047,440	34
	C. Ancillary Expense		
35	Special Cost Centers	698,502	35
36	Provider Participation Fee	181,520	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,250,528	40
41	Income before Income Taxes (line 30 minus line 40)**	313,086	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 313,086	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,336,159	44
45	Private Pay - Net Inpatient Revenue	111,337	45
46	Medicare - Net Inpatient Revenue	1,125,651	46
47	Other-(specify) <u>Insurance</u>	134,430	47
48	Other-(specify) <u>Hospice</u>	78,976	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,786,553	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Filed Yet If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,168	2,296	\$ 97,132	\$ 42.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,609	8,283	284,374	34.33	3
4	Licensed Practical Nurses	16,820	18,206	546,034	29.99	4
5	CNAs & Orderlies	25,267	27,109	443,517	16.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,707	1,858	31,005	16.69	10
11	Social Service Workers	2,047	2,135	49,197	23.04	11
12	Dietician					12
13	Food Service Supervisor	2,467	2,854	51,985	18.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,956	8,574	111,231	12.97	15
16	Dishwashers					16
17	Maintenance Workers	1,675	1,913	69,084	36.11	17
18	Housekeepers	8,137	8,885	122,319	13.77	18
19	Laundry	3,457	3,739	41,828	11.19	19
20	Administrator	1,768	1,998	103,579	51.84	20
21	Assistant Administrator					21
22	Other Administrative	1,424	1,779	46,215	25.98	22
23	Office Manager	2,118	2,396	75,200	31.39	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	2,012	2,204	52,066	23.62	31
32	Other Health C: Respiratory Thera	21,643	23,725	683,032	28.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,275	117,954	\$ 2,807,798 *	\$ 23.80	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		\$ 12,931	1, 3	35
36	Medical Director		36,675	9, 3	36
37	Medical Records Consultant		6,474	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,224	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,467	11, 3	44
45	Social Service Consultant		2,577	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 66,348		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	13	\$ 933	10, 3	50
51	Licensed Practical Nurses	837	44,672	10, 3	51
52	Certified Nurse Assistants/Aides	13,131	420,043	10, 3	52
53	TOTAL (lines 50 - 52)	13,981	\$ 465,648		53

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Helia Healthcare Belleville

0048827

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Latasha Hamilton

Administrator

0

\$ 103,579

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 103,579

B. Administrative - Other

Description

Amount

Bridgemark Healthcare LLC - Management Fees

\$ 363,600

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 363,600

C. Professional Services

Vendor/Payee

Type

Amount

Personnel Planners

Unemployment Consulting

\$ 1,916

Much Shelist

Legal Fees

3,371

Stein Law

Legal Services

1,020

Hamlin & Burton Liability Managem

Legal Fees

20,279

O'Halloran, Kosoff, Geitner & Cook,

Legal Fees

10,237

US Bank Equip

3,225

C.J. Schlosser & Company, LLC

Accounting Services

4,000

Sandberg Phoenix & Von Gontard P

Legal Fees

951

Paycom Payroll

Payroll Processing

23,039

Pantegra

401k Admin

3,100

Nationwide Trust

401k Admin

978

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 72,116

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 30,481

Unemployment Compensation Insurance

12,415

FICA Taxes

211,903

Employee Health Insurance

35,023

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k Match

8,672

Employee Benefits

557

Related Party Allocation - Bridgemark

11,701

TOTAL (agree to Schedule V, line 22, col.8)

\$ 310,752

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

Section N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

6,270

Health Care Worker Background Check

1,094

(Indicate # of checks performed)

Patient Background Checks

Dues & Subscriptions

5,211

IHCA Dues

6,370

Advertising

17,204

Miscellaneous Licenses & Fees

2,707

Related Party Allocation - Bridgemark

1,067

Less: Public Relations Expense

()

Non-allowable advertising

(17,204)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 24,709

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

199

Seminar Expense

240

Related Party Allocation - Bridgemark

1,764

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 2,203

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$ 6,370
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,715 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. \$ 181,520
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 450
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT