

|  |  |             |  |  |  |  |  |
|--|--|-------------|--|--|--|--|--|
|  |  | 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: 0049775

Facility Name: Helia Healthcare of Benton

Address: 1310 Mark Frankln Dr Benton 62812  
Number City Zip Code

County: Franklin

Telephone Number: (618) 932-3236 Fax # (618) 937-1171

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT  
☐ Charitable Corp.  
☐ Trust  
IRS Exemption Code

☒ PROPRIETARY  
☐ Individual  
☐ Partnership  
☐ Corporation  
☐ "Sub-S" Corp.  
☒ Limited Liability Co.  
☐ Trust  
☐ Other

☐ GOVERNMENTAL  
☐ State  
☐ County  
☐ Other

In the event there are further questions about this report, please contact:  
Name: Cindy A. Tefteller Telephone Number: (618) 465-7717  
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or  
Administrator  
of Provider

(Signed)  
(Type or Print Name) Jason Mills  
(Title) Chief Financial Officer

Paid  
Preparer

(Signed) See Accountant's Preparation Report  
(Print Name and Title) Cindy A. Tefteller Partner  
(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002  
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE  
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton

# 0049775 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 <u>N/A</u> |                                    |                             |                              |                                        |   |
|                                                                                                                                                   | 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                                                                                                                                                 | 83                                 | Skilled (SNF)               | 83                           | 30,378                                 | 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                                                                                                                                                 | 83                                 | TOTALS                      | 83                           | 30,378                                 | 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           | 10,821                                                      | 4,967       | 3,914 | 19,702 | 8  |
| 9                                       | SNF/PED       |                                                             |             |       |        | 9  |
| 10                                      | ICF           |                                                             |             |       |        | 10 |
| 11                                      | ICF/DD        |                                                             |             |       |        | 11 |
| 12                                      | SC            |                                                             |             |       |        | 12 |
| 13                                      | DD 16 OR LESS |                                                             |             |       |        | 13 |
| 14                                      | TOTALS        | 10,821                                                      | 4,967       | 3,914 | 19,702 | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.86%

SEE ACCOUNTANTS' PREPARATION REPORT

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 8/15/08

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 8/15/08 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 83 and days of care provided 3,659

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number      Helia Healthcare of Benton      #      0049775      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-<br>ification<br>5 | Reclassified<br>Total<br>6 | Adjust-<br>ments<br>7 | Adjusted<br>Total<br>8 | FOR BHF USE ONLY |    |     |
|-----|------------------------------------------------------------------|--------------------------|---------------|------------|------------|----------------------------|----------------------------|-----------------------|------------------------|------------------|----|-----|
|     |                                                                  | Salary/Wage<br>1         | Supplies<br>2 | Other<br>3 | Total<br>4 |                            |                            |                       |                        | 9                | 10 |     |
|     | <b>A. General Services</b>                                       |                          |               |            |            |                            |                            |                       |                        |                  |    |     |
| 1   | Dietary                                                          | 87,346                   | 37,178        | 124,826    | 249,350    |                            | 249,350                    |                       | 249,350                |                  |    | 1   |
| 2   | Food Purchase                                                    |                          | 134,907       |            | 134,907    |                            | 134,907                    | (168)                 | 134,739                |                  |    | 2   |
| 3   | Housekeeping                                                     | 118,990                  | 23,616        |            | 142,606    |                            | 142,606                    |                       | 142,606                |                  |    | 3   |
| 4   | Laundry                                                          | 15,815                   | 8,991         | 79,090     | 103,896    |                            | 103,896                    | (22,472)              | 81,424                 |                  |    | 4   |
| 5   | Heat and Other Utilities                                         |                          |               | 94,422     | 94,422     |                            | 94,422                     | 3,085                 | 97,507                 |                  |    | 5   |
| 6   | Maintenance                                                      | 11,332                   | 18,695        | 37,321     | 67,348     |                            | 67,348                     | 56,504                | 123,852                |                  |    | 6   |
| 7   | Other (specify):*                                                |                          |               |            |            |                            |                            |                       |                        |                  |    | 7   |
| 8   | <b>TOTAL General Services</b>                                    | 233,483                  | 223,387       | 335,659    | 792,529    |                            | 792,529                    | 36,949                | 829,478                |                  |    | 8   |
|     | <b>B. Health Care and Programs</b>                               |                          |               |            |            |                            |                            |                       |                        |                  |    |     |
| 9   | Medical Director                                                 |                          |               | 18,890     | 18,890     |                            | 18,890                     |                       | 18,890                 |                  |    | 9   |
| 10  | Nursing and Medical Records                                      | 1,211,532                | 97,844        | 8,864      | 1,318,240  |                            | 1,318,240                  | 21,923                | 1,340,163              |                  |    | 10  |
| 10a | Therapy                                                          |                          |               |            |            |                            |                            |                       |                        |                  |    | 10a |
| 11  | Activities                                                       | 57,866                   | 7,449         | 905        | 66,220     |                            | 66,220                     | (916)                 | 65,304                 |                  |    | 11  |
| 12  | Social Services                                                  | 46,133                   | 119           | 1,886      | 48,138     |                            | 48,138                     |                       | 48,138                 |                  |    | 12  |
| 13  | CNA Training                                                     |                          |               |            |            |                            |                            |                       |                        |                  |    | 13  |
| 14  | Program Transportation                                           |                          |               |            |            |                            |                            |                       |                        |                  |    | 14  |
| 15  | Other (specify):*                                                |                          |               |            |            |                            |                            |                       |                        |                  |    | 15  |
| 16  | <b>TOTAL Health Care and Programs</b>                            | 1,315,531                | 105,412       | 30,545     | 1,451,488  |                            | 1,451,488                  | 21,007                | 1,472,495              |                  |    | 16  |
|     | <b>C. General Administration</b>                                 |                          |               |            |            |                            |                            |                       |                        |                  |    |     |
| 17  | Administrative                                                   | 101,359                  |               | 234,000    | 335,359    |                            | 335,359                    | (214,240)             | 121,119                |                  |    | 17  |
| 18  | Directors Fees                                                   |                          |               |            |            |                            |                            |                       |                        |                  |    | 18  |
| 19  | Professional Services                                            |                          |               | 25,370     | 25,370     |                            | 25,370                     | 6,416                 | 31,786                 |                  |    | 19  |
| 20  | Dues, Fees, Subscriptions & Promotions                           |                          |               | 68,228     | 68,228     |                            | 68,228                     | (47,029)              | 21,199                 |                  |    | 20  |
| 21  | Clerical & General Office Expenses                               | 65,722                   | 15,793        | 109,351    | 190,866    |                            | 190,866                    | 101,230               | 292,096                |                  |    | 21  |
| 22  | Employee Benefits & Payroll Taxes                                |                          |               | 183,460    | 183,460    |                            | 183,460                    | 31,070                | 214,530                |                  |    | 22  |
| 23  | Inservice Training & Education                                   |                          |               |            |            |                            |                            |                       |                        |                  |    | 23  |
| 24  | Travel and Seminar                                               |                          |               | 475        | 475        |                            | 475                        | 1,730                 | 2,205                  |                  |    | 24  |
| 25  | Other Admin. Staff Transportation                                |                          |               | 3,799      | 3,799      |                            | 3,799                      | 17,003                | 20,802                 |                  |    | 25  |
| 26  | Insurance-Prop.Liab.Malpractice                                  |                          |               | 27,316     | 27,316     |                            | 27,316                     | 17,681                | 44,997                 |                  |    | 26  |
| 27  | Other (specify):*                                                |                          |               |            |            |                            |                            |                       |                        |                  |    | 27  |
| 28  | <b>TOTAL General Administration</b>                              | 167,081                  | 15,793        | 651,999    | 834,873    |                            | 834,873                    | (86,139)              | 748,734                |                  |    | 28  |
| 29  | <b>TOTAL Operating Expense<br/>(sum of lines 8, 16 &amp; 28)</b> | 1,716,095                | 344,592       | 1,018,203  | 3,078,890  |                            | 3,078,890                  | (28,183)              | 3,050,707              |                  |    | 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                       |                         |          | 25,103    | 25,103    |                   | 25,103             | 12,069       | 37,172         |                  |    | 30 |
| 31 | Amortization of Pre-Op. & Org.     |                         |          |           |           |                   |                    |              |                |                  |    | 31 |
| 32 | Interest                           |                         |          | 29,991    | 29,991    |                   | 29,991             | (1,192)      | 28,799         |                  |    | 32 |
| 33 | Real Estate Taxes                  |                         |          | 21,000    | 21,000    |                   | 21,000             | 1,115        | 22,115         |                  |    | 33 |
| 34 | Rent-Facility & Grounds            |                         |          | 307,263   | 307,263   |                   | 307,263            | (296,773)    | 10,490         |                  |    | 34 |
| 35 | Rent-Equipment & Vehicles          |                         |          | 18,238    | 18,238    |                   | 18,238             | 772          | 19,010         |                  |    | 35 |
| 36 | Other (specify):*                  |                         |          |           |           |                   |                    |              |                |                  |    | 36 |
| 37 | TOTAL Ownership                    |                         |          | 401,595   | 401,595   |                   | 401,595            | (284,009)    | 117,586        |                  |    | 37 |
|    | Ancillary Expense                  |                         |          |           |           |                   |                    |              |                |                  |    |    |
|    | E. Special Cost Centers            |                         |          |           |           |                   |                    |              |                |                  |    |    |
| 38 | Medically Necessary Transportation |                         |          |           |           |                   |                    |              |                |                  |    | 38 |
| 39 | Ancillary Service Centers          |                         | 126,200  | 431,945   | 558,145   |                   | 558,145            |              | 558,145        |                  |    | 39 |
| 40 | Barber and Beauty Shops            |                         |          |           |           |                   |                    |              |                |                  |    | 40 |
| 41 | Coffee and Gift Shops              |                         |          |           |           |                   |                    |              |                |                  |    | 41 |
| 42 | Provider Participation Fee         |                         |          | 152,189   | 152,189   |                   | 152,189            |              | 152,189        |                  |    | 42 |
| 43 | Other (specify):*                  |                         |          |           |           |                   |                    |              |                |                  |    | 43 |
| 44 | TOTAL Special Cost Centers         |                         | 126,200  | 584,134   | 710,334   |                   | 710,334            |              | 710,334        |                  |    | 44 |
|    | GRAND TOTAL COST                   |                         |          |           |           |                   |                    |              |                |                  |    |    |
| 45 | (sum of lines 29, 37 & 44)         | 1,716,095               | 470,792  | 2,003,932 | 4,190,819 |                   | 4,190,819          | (312,192)    | 3,878,627      |                  |    | 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.)

|    | NON-ALLOWABLE EXPENSES                                         | 1<br>Amount | 2<br>Refer-<br>ence | 3<br>BHF USE<br>ONLY |    |
|----|----------------------------------------------------------------|-------------|---------------------|----------------------|----|
| 1  | Day Care                                                       | \$          |                     | \$                   | 1  |
| 2  | Other Care for Outpatients                                     |             |                     |                      | 2  |
| 3  | Governmental Sponsored Special Programs                        |             |                     |                      | 3  |
| 4  | Non-Patient Meals                                              | (916)       | 11                  |                      | 4  |
| 5  | Telephone, TV & Radio in Resident Rooms                        | (6,634)     | 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                           | (1,192)     | 32                  |                      | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds                       |             |                     |                      | 11 |
| 12 | Non-Working Officer's or Owner's Salary                        |             |                     |                      | 12 |
| 13 | Sales Tax                                                      | (168)       | 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                                          | (200)       | 20                  |                      | 17 |
| 18 | Fines and Penalties                                            |             |                     |                      | 18 |
| 19 | Entertainment                                                  | (2,235)     | 21                  |                      | 19 |
| 20 | Contributions                                                  | (1,050)     | 21                  |                      | 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                      | (39,120)    | 20                  |                      | 25 |
| 26 | Income Taxes and Illinois Personal<br>Property Replacement Tax |             |                     |                      | 26 |
| 27 | CNA Training for Non-Employees                                 |             |                     |                      | 27 |
| 28 | Yellow Page Advertising                                        |             |                     |                      | 28 |
| 29 | Other-Attach Schedule                                          | (9,085)     | Var.                |                      | 29 |
| 30 | SUBTOTAL (A): (Sum of lines 1-29)                              | \$ (60,600) |                     | \$                   | 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<br>Amount  | 2<br>Reference |    |
|----|--------------------------------------------------------------|--------------|----------------|----|
| 31 | Non-Paid Workers-Attach Schedule*                            | \$           |                | 31 |
| 32 | Donated Goods-Attach Schedule*                               |              |                | 32 |
| 33 | Amortization of Organization &<br>Pre-Operating Expense      |              |                | 33 |
| 34 | Adjustments for Related Organization<br>Costs (Schedule VII) | (251,592)    | Var.           | 34 |
| 35 | Other- Attach Schedule                                       |              |                | 35 |
| 36 | SUBTOTAL (B): (sum of lines 31-35)                           | \$ (251,592) |                | 36 |
| 37 | (sum of SUBTOTALS<br>TOTAL ADJUSTMENTS (A) and (B) )         | \$ (312,192) |                | 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<br>Yes | 2<br>No | 3<br>Amount | 4<br>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<br>Reference |    |
|------------------------|--------------------------------------|------------|--------------------------|----|
| 1                      | To Eliminate Gifts and Flowers       | \$ (6,521) | 20                       | 1  |
| 2                      | To Eliminate Lobbying/PAC Dues       | (2,040)    | 20                       | 2  |
| 3                      | To Eliminate out of period IDPH Fees | (524)      | 20                       | 3  |
| 4                      |                                      |            |                          | 4  |
| 5                      |                                      |            |                          | 5  |
| 6                      |                                      |            |                          | 6  |
| 7                      |                                      |            |                          | 7  |
| 8                      |                                      |            |                          | 8  |
| 9                      |                                      |            |                          | 9  |
| 10                     |                                      |            |                          | 10 |
| 11                     |                                      |            |                          | 11 |
| 12                     |                                      |            |                          | 12 |
| 13                     |                                      |            |                          | 13 |
| 14                     |                                      |            |                          | 14 |
| 15                     |                                      |            |                          | 15 |
| 16                     |                                      |            |                          | 16 |
| 17                     |                                      |            |                          | 17 |
| 18                     |                                      |            |                          | 18 |
| 19                     |                                      |            |                          | 19 |
| 20                     |                                      |            |                          | 20 |
| 21                     |                                      |            |                          | 21 |
| 22                     |                                      |            |                          | 22 |
| 23                     |                                      |            |                          | 23 |
| 24                     |                                      |            |                          | 24 |
| 25                     |                                      |            |                          | 25 |
| 26                     |                                      |            |                          | 26 |
| 27                     |                                      |            |                          | 27 |
| 28                     |                                      |            |                          | 28 |
| 29                     |                                      |            |                          | 29 |
| 30                     |                                      |            |                          | 30 |
| 31                     |                                      |            |                          | 31 |
| 32                     |                                      |            |                          | 32 |
| 33                     |                                      |            |                          | 33 |
| 34                     |                                      |            |                          | 34 |
| 35                     |                                      |            |                          | 35 |
| 36                     |                                      |            |                          | 36 |
| 37                     |                                      |            |                          | 37 |
| 38                     |                                      |            |                          | 38 |
| 39                     |                                      |            |                          | 39 |
| 40                     |                                      |            |                          | 40 |
| 41                     |                                      |            |                          | 41 |
| 42                     |                                      |            |                          | 42 |
| 43                     |                                      |            |                          | 43 |
| 44                     |                                      |            |                          | 44 |
| 45                     |                                      |            |                          | 45 |
| 46                     |                                      |            |                          | 46 |
| 47                     |                                      |            |                          | 47 |
| 48                     |                                      |            |                          | 48 |
| 49                     | Total                                | (9,085)    |                          | 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<br>OWNERS              |             | 2<br>RELATED NURSING HOMES                     |                           | 3<br>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 Belleville</u>          | <u>Belleville, IL</u>     | <u>Bridgemark Healthcar</u>          | <u>St. Ann, MO</u>     | <u>Management Co</u>       |
|                          |             | <u>Helia Healthcare of Energy</u>              | <u>Energy, IL</u>         | <u>Helia Healthcare Servi</u>        | <u>Benton, IL</u>      | <u>Laundry, Maint. Ser</u> |
|                          |             | <u>Helia Healthcare of Olney</u>               | <u>Olney, IL</u>          | <u>Bridgemark Employer</u>           | <u>St. Ann, MO</u>     | <u>Human Resources</u>     |
|                          |             | <u>Frankfort Healthcare &amp; Rehab Center</u> | <u>West Frankfort, IL</u> | <u>NW Rehab, LLC</u>                 | <u>St. Louis, MO</u>   | <u>Therapy</u>             |
|                          |             | <u>Helia Southbelt Healthcare</u>              | <u>Belleville, IL</u>     | <u>Palladian Management</u>          | <u>O'Fallon, IL</u>    | <u>Management Co</u>       |
|                          |             | <u>Hillside Rehab &amp; Care Center</u>        | <u>Yorkville, IL</u>      | <u>Palladian Mt. Vernon</u>          | <u>Mt. Vernon, IL</u>  | <u>Assisted Living</u>     |
|                          |             | <u>Helia Helathcare of Hillsboro</u>           | <u>Hillsboro, IL</u>      | <u>Palladian Taylorville A</u>       | <u>Taylorville, IL</u> | <u>Assisted Living</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     | 4    | <u>Laundry</u>                         | \$ <u>79,090</u> | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | \$ <u>56,618</u>                       | \$ <u>(22,472)</u>                                     | 1  |
| 2          | V     | 5    | <u>Utilities</u>                       |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>9,327</u>                           | <u>9,327</u>                                           | 2  |
| 3          | V     | 6    | <u>Maintenance</u>                     | <u>2,750</u>     | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>59,254</u>                          | <u>56,504</u>                                          | 3  |
| 4          | V     | 20   | <u>Dues, Fees, &amp; Subscriptions</u> |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>330</u>                             | <u>330</u>                                             | 4  |
| 5          | V     | 21   | <u>Clerical</u>                        |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>2,597</u>                           | <u>2,597</u>                                           | 5  |
| 6          | V     | 22   | <u>Employee Benefits</u>               |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>19,596</u>                          | <u>19,596</u>                                          | 6  |
| 7          | V     | 25   | <u>Admin Staff Travel</u>              |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>14,533</u>                          | <u>14,533</u>                                          | 7  |
| 8          | V     | 26   | <u>Insurance</u>                       |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>1,045</u>                           | <u>1,045</u>                                           | 8  |
| 9          | V     | 30   | <u>Depreciation</u>                    |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>4,791</u>                           | <u>4,791</u>                                           | 9  |
| 10         | V     | 33   | <u>Real Estate Taxes</u>               |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>1,452</u>                           | <u>1,452</u>                                           | 10 |
| 11         | V     | 34   | <u>Rent - Facility</u>                 |                  | <u>Helia Healthcare Services</u> | <u>100.00%</u>       | <u>982</u>                             | <u>982</u>                                             | 11 |
| 12         | V     |      |                                        |                  |                                  |                      |                                        |                                                        | 12 |
| 13         | V     |      |                                        |                  |                                  |                      |                                        |                                                        | 13 |
| 14         | Total |      |                                        | \$ <u>81,840</u> |                                  |                      | \$ <u>170,525</u>                      | \$ * <u>88,685</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.** ☒ 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     | 5    | Utilities                  | \$         | Bridgemark Healthcare, LLC     | 100.00%              | \$ 392                                 | \$ 392                                                 | 15 |
| 16         | V     | 10   | Nursing & Med              |            | Bridgemark Healthcare, LLC     | 100.00%              | 21,923                                 | 21,923                                                 | 16 |
| 17         | V     | 17   | Management Fees            | 234,000    | Bridgemark Healthcare, LLC     | 100.00%              | 19,760                                 | (214,240)                                              | 17 |
| 18         | V     | 19   | Professional Fees          |            | Bridgemark Healthcare, LLC     | 100.00%              | 6,416                                  | 6,416                                                  | 18 |
| 19         | V     | 20   | Dues, Subscriptions        |            | Bridgemark Healthcare, LLC     | 100.00%              | 1,046                                  | 1,046                                                  | 19 |
| 20         | V     | 21   | Clerical & General Office  |            | Bridgemark Healthcare, LLC     | 100.00%              | 101,918                                | 101,918                                                | 20 |
| 21         | V     | 22   | Employee Benefits          |            | Bridgemark Healthcare, LLC     | 100.00%              | 11,474                                 | 11,474                                                 | 21 |
| 22         | V     | 24   | Travel & Seminars          |            | Bridgemark Healthcare, LLC     | 100.00%              | 1,730                                  | 1,730                                                  | 22 |
| 23         | V     | 25   | Admin Staff Transportation |            | Bridgemark Healthcare, LLC     | 100.00%              | 2,470                                  | 2,470                                                  | 23 |
| 24         | V     | 26   | Insurance                  |            | Bridgemark Healthcare, LLC     | 100.00%              | 16,636                                 | 16,636                                                 | 24 |
| 25         | V     | 30   | Depreciation               |            | Bridgemark Healthcare, LLC     | 100.00%              | 2,808                                  | 2,808                                                  | 25 |
| 26         | V     | 33   | Real Estate Taxes          |            | Bridgemark Healthcare, LLC     | 100.00%              | 31                                     | 31                                                     | 26 |
| 27         | V     | 34   | Rent                       |            | Bridgemark Healthcare, LLC     | 100.00%              | 5,195                                  | 5,195                                                  | 27 |
| 28         | V     | 35   | Equipment Rental           |            | Bridgemark Healthcare, LLC     | 100.00%              | 772                                    | 772                                                    | 28 |
| 29         | V     |      |                            |            |                                |                      |                                        |                                                        | 29 |
| 30         | V     |      |                            |            |                                |                      |                                        |                                                        | 30 |
| 31         | V     |      |                            |            |                                |                      |                                        |                                                        | 31 |
| 32         | V     | 30   | Depreciation               |            | BM Properties 1 - Benton       | 100.00%              | 4,470                                  | 4,470                                                  | 32 |
| 33         | V     | 33   | Real Estate Taxes          | 21,000     | BM Properties 1 - Benton       | 100.00%              | 20,632                                 | (368)                                                  | 33 |
| 34         | V     | 34   | Rent                       | 302,950    | BM Properties 1 - Benton       | 100.00%              |                                        | (302,950)                                              | 34 |
| 35         | V     |      |                            |            |                                |                      |                                        |                                                        | 35 |
| 36         | V     |      |                            |            |                                |                      |                                        |                                                        | 36 |
| 37         | V     |      |                            |            |                                |                      |                                        |                                                        | 37 |
| 38         | V     |      |                            |            |                                |                      |                                        |                                                        | 38 |
| 39         | Total |      |                            | \$ 557,950 |                                |                      | \$ 217,673                             | \$ * (340,277)                                         | 39 |

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

**SEE ACCOUNTANTS' PREPARATION REPORT**



VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

|    | 1<br>OWNERS |             | 2<br>RELATED NURSING HOMES                 |                  | 3<br>OTHER RELATED BUSINESS ENTITIES |      |                  |    |
|----|-------------|-------------|--------------------------------------------|------------------|--------------------------------------|------|------------------|----|
|    | Name        | Ownership % | Name                                       | City             | Name                                 | City | Type of Business |    |
| 1  |             |             | Helia Healthcare of Florissant             | Florissant, MO   |                                      |      |                  | 1  |
| 2  |             |             | Helia Healthcare of Jerseyville            | Jerseyville, IL  |                                      |      |                  | 2  |
| 3  |             |             | Helia Healthcare of Poplar Bluff           | Poplar Bluff, MO |                                      |      |                  | 3  |
| 4  |             |             | Helia Healthcare of Effingham              | Effingham, IL    |                                      |      |                  | 4  |
| 5  |             |             | Helia Healthcare of Salem                  | Salem, IL        |                                      |      |                  | 5  |
| 6  |             |             | Palladian Senior Care of Poplar Bluff, LLC | Poplar Bluff, MO |                                      |      |                  | 6  |
| 7  |             |             | Helia Richland Healthcare, LLC             | Olney, IL        |                                      |      |                  | 7  |
| 8  |             |             | Helia Healthcare of Newton, LLC            | Newton, IL       |                                      |      |                  | 8  |
| 9  |             |             | Palladian Aviston SNF, LLC                 | Aviston, IL      |                                      |      |                  | 9  |
| 10 |             |             | Palladian Mt. Vernon SNF, LLC              | Mt. Vernon, IL   |                                      |      |                  | 10 |
| 11 |             |             | Palladian Taylorville SNF, LLC             | Taylorville, IL  |                                      |      |                  | 11 |
| 12 |             |             |                                            |                  |                                      |      |                  | 12 |
| 13 |             |             |                                            |                  |                                      |      |                  | 13 |
| 14 |             |             |                                            |                  |                                      |      |                  | 14 |
| 15 |             |             |                                            |                  |                                      |      |                  | 15 |
| 16 |             |             |                                            |                  |                                      |      |                  | 16 |
| 17 |             |             |                                            |                  |                                      |      |                  | 17 |
| 18 |             |             |                                            |                  |                                      |      |                  | 18 |
| 19 |             |             |                                            |                  |                                      |      |                  | 19 |
| 20 |             |             |                                            |                  |                                      |      |                  | 20 |
| 21 |             |             |                                            |                  |                                      |      |                  | 21 |
| 22 |             |             |                                            |                  |                                      |      |                  | 22 |
| 23 |             |             |                                            |                  |                                      |      |                  | 23 |
| 24 |             |             |                                            |                  |                                      |      |                  | 24 |
| 25 |             |             |                                            |                  |                                      |      |                  | 25 |
| 26 |             |             |                                            |                  |                                      |      |                  | 26 |
| 27 |             |             |                                            |                  |                                      |      |                  | 27 |
| 28 |             |             |                                            |                  |                                      |      |                  | 28 |
| 29 |             |             |                                            |                  |                                      |      |                  | 29 |
| 30 |             |             |                                            |                  |                                      |      |                  | 30 |

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 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<br>Name         | 2<br>Title | 3<br>Function  | 4<br>Ownership Interest | 5<br>Compensation Received From Other Nursing Homes* | 6<br>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week |         | 7<br>Compensation Included in Costs for this Reporting Period** |           | 8<br>Schedule V. Line & Column Reference |    |
|----|-------------------|------------|----------------|-------------------------|------------------------------------------------------|------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------|-----------|------------------------------------------|----|
|    |                   |            |                |                         |                                                      | Hours                                                                              | Percent | Description                                                     | Amount    |                                          |    |
| 1  | Stephen P. Miller | Owner      | Administration | 100.00                  | 386,668                                              | 2.43                                                                               | 4.86    | Distribution                                                    | \$ 19,760 | 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                                                           | \$ 19,760 |                                          | 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

**Ending: 2/31/2020**

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

**SEE ACCOUNTANTS' PREPARATION REPORT**

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Helia Healthcare Services  
Street Address 308 N. Mcleansboro Street  
City / State / Zip Code Benton, IL 62812  
Phone Number (618) 435-3304  
Fax Number ( )

|    | 1          | 2                           | 3                        | 4           | 5               | 6              | 7                | 8        | 9                    |    |
|----|------------|-----------------------------|--------------------------|-------------|-----------------|----------------|------------------|----------|----------------------|----|
|    | Schedule V |                             | Unit of Allocation       |             | Number of       | Total Indirect | Amount of Salary | Facility | Allocation           |    |
|    | Line       | Item                        | (i.e.,Days, Direct Cost, | Total Units | Subunits Being  | Cost Being     | Cost Contained   | Units    | (col.8/col.4)x col.6 |    |
|    | Reference  |                             | Square Feet)             |             | Allocated Among | Allocated      | in Column 6      |          |                      |    |
| 1  | 4          | Laundry                     | Revenue                  | 227,980     | 3               | \$ 157,720     | \$ 145,852       | 81,840   | \$ 56,618            | 1  |
| 2  | 5          | Utilities                   | Revenue                  | 227,980     | 3               | 25,982         |                  | 81,840   | 9,327                | 2  |
| 3  | 6          | Maintenance                 | Revenue                  | 227,980     | 3               | 165,062        | 156,354          | 81,840   | 59,254               | 3  |
| 4  | 20         | Dues, Fees, & Subscriptions | Revenue                  | 227,980     | 3               | 920            |                  | 81,840   | 330                  | 4  |
| 5  | 21         | Clerical & Office Supplies  | Revenue                  | 227,980     | 3               | 7,235          |                  | 81,840   | 2,597                | 5  |
| 6  | 22         | Payroll Taxes & Emp. Ben.   | Revenue                  | 227,980     | 3               | 54,589         |                  | 81,840   | 19,596               | 6  |
| 7  | 25         | Other Admin Tranp           | Revenue                  | 227,980     | 3               | 40,485         |                  | 81,840   | 14,533               | 7  |
| 8  | 26         | Insurance                   | Revenue                  | 227,980     | 3               | 2,911          |                  | 81,840   | 1,045                | 8  |
| 9  | 30         | Depreciation                | Revenue                  | 227,980     | 3               | 13,347         |                  | 81,840   | 4,791                | 9  |
| 10 | 33         | Real Estate Taxes           | Revenue                  | 227,980     | 3               | 4,046          |                  | 81,840   | 1,452                | 10 |
| 11 | 34         | Rent - Facility             | Revenue                  | 227,980     | 3               | 2,736          |                  | 81,840   | 982                  | 11 |
| 12 |            |                             |                          |             |                 |                |                  |          |                      | 12 |
| 13 |            |                             |                          |             |                 |                |                  |          |                      | 13 |
| 14 |            |                             |                          |             |                 |                |                  |          |                      | 14 |
| 15 |            |                             |                          |             |                 |                |                  |          |                      | 15 |
| 16 |            |                             |                          |             |                 |                |                  |          |                      | 16 |
| 17 |            |                             |                          |             |                 |                |                  |          |                      | 17 |
| 18 |            |                             |                          |             |                 |                |                  |          |                      | 18 |
| 19 |            |                             |                          |             |                 |                |                  |          |                      | 19 |
| 20 |            |                             |                          |             |                 |                |                  |          |                      | 20 |
| 21 |            |                             |                          |             |                 |                |                  |          |                      | 21 |
| 22 |            |                             |                          |             |                 |                |                  |          |                      | 22 |
| 23 |            |                             |                          |             |                 |                |                  |          |                      | 23 |
| 24 |            |                             |                          |             |                 |                |                  |          |                      | 24 |
| 25 | TOTALS     |                             |                          |             |                 | \$ 475,033     | \$ 302,206       |          | \$ 170,525           | 25 |

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     |                |          |               | Variable                 | 28,368                            | 6  |
| 7  | Medline                      |           | X  | Vendor Note       |                          | 11/15/19     |                |          |               | 8.0000                   | 944                               | 7  |
| 8  | Cook Portable Warehouses     |           | X  | Portable Building | \$254.00                 | 08/01/20     | 5,342          | 5,005    | 08/01/2023    |                          | 679                               | 8  |
| 9  | TOTAL Facility Related       |           |    |                   | \$254.00                 |              | \$ 5,342       | \$ 5,005 |               |                          | \$ 29,991                         | 9  |
|    | B. Non-Facility Related*     |           |    |                   |                          |              |                |          |               |                          |                                   |    |
| 10 | Interest Income Offset       |           |    |                   |                          |              |                |          |               |                          | (1,192)                           | 10 |
| 11 |                              |           |    |                   |                          |              |                |          |               |                          |                                   | 11 |
| 12 |                              |           |    |                   |                          |              |                |          |               |                          |                                   | 12 |
| 13 |                              |           |    |                   |                          |              |                |          |               |                          |                                   | 13 |
| 14 | TOTAL Non-Facility Related   |           |    |                   |                          |              | \$             | \$       |               |                          | \$ (1,192)                        | 14 |
| 15 | TOTALS (line 9+line14)       |           |    |                   |                          |              | \$ 5,342       | \$ 5,005 |               |                          | \$ 28,799                         | 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.)



2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

A. Summary of Real Estate Tax Cost

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.

| (A)              | (B)                  | (C)          | (D)<br>Tax<br>Applicable to<br>Nursing Home |
|------------------|----------------------|--------------|---------------------------------------------|
| Tax Index Number | Property Description | Total Tax    |                                             |
| 1. 08-07-455-802 | Nursing Home         | \$ 20,631.56 | \$ 20,631.56                                |
| 2.               |                      | \$           | \$                                          |
| 3.               |                      | \$           | \$                                          |
| 4.               |                      | \$           | \$                                          |
| 5.               |                      | \$           | \$                                          |
| 6.               |                      | \$           | \$                                          |
| 7.               |                      | \$           | \$                                          |
| 8.               |                      | \$           | \$                                          |
| 9.               |                      | \$           | \$                                          |
| 10.              |                      | \$           | \$                                          |
| TOTALS           |                      | \$ 20,631.56 | \$ 20,631.56                                |

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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:

39,067

B. General Construction Type:

Exterior

Brick Masonry

Frame

Metal

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        | Related Party Allocation - Helia Healthcare |             |               | \$ 1,798 | 1 |
| 2        |                                             |             |               |          | 2 |
| 3        | TOTALS                                      |             |               | \$ 1,798 | 3 |

SEE ACCOUNTANTS' PREPARATION REPORT



**XI. OWNERSHIP COSTS (continued)**

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

|    | 1                                                                    | 2                | 3                | 4                   | 5         | 6                            | 7                | 8                             | 9           |                             |    |
|----|----------------------------------------------------------------------|------------------|------------------|---------------------|-----------|------------------------------|------------------|-------------------------------|-------------|-----------------------------|----|
|    | Beds*                                                                | FOR BHF USE ONLY | Year<br>Acquired | Year<br>Constructed | Cost      | Current Book<br>Depreciation | Life<br>in Years | Straight Line<br>Depreciation | Adjustments | Accumulated<br>Depreciation |    |
| 4  | Helia Healthcare Allocation                                          |                  | 2006             |                     | \$ 47,936 | \$                           | 25               | \$ 2,397                      | \$ 2,397    | \$ 15,692                   | 4  |
| 5  | 83                                                                   |                  | 2008             |                     | 134,098   |                              | 30               | 4,470                         | 4,470       | 55,502                      | 5  |
| 6  |                                                                      |                  |                  |                     |           |                              |                  |                               |             |                             | 6  |
| 7  |                                                                      |                  |                  |                     |           |                              |                  |                               |             |                             | 7  |
| 8  |                                                                      |                  |                  |                     |           |                              |                  |                               |             |                             | 8  |
|    | Improvement Type**                                                   |                  |                  |                     |           |                              |                  |                               |             |                             |    |
| 9  | Nurse's Station                                                      |                  |                  | 2009                | 1,221     | 81                           | 15               | 81                            |             | 970                         | 9  |
| 10 | Exterior Sign                                                        |                  |                  | 2009                | 5,265     |                              | 10               |                               |             | 5,265                       | 10 |
| 11 | Wallcoverings for hallways & entranceway, doors, shower remodel      |                  |                  | 2009                | 11,252    | 750                          | 15               | 750                           |             | 8,502                       | 11 |
| 12 | Nurse's Station Remodel/Wiring                                       |                  |                  | 2009                | 2,556     | 170                          | 15               | 170                           |             | 1,917                       | 12 |
| 13 | New Pipes, Install Eye Wash                                          |                  |                  | 2010                | 2,215     | 89                           | 25               | 89                            |             | 938                         | 13 |
| 14 | AC, Fans, Dehumidifier                                               |                  |                  | 2010                | 1,609     | 80                           | 10               | 80                            |             | 1,609                       | 14 |
| 15 | Outside Singe Door & Frame                                           |                  |                  | 2010                | 4,168     | 278                          | 15               | 278                           |             | 2,848                       | 15 |
| 16 | Shower Room - Tile, shower heards, electrical work, fixtures, paint  |                  |                  | 2011                | 3,860     | 257                          | 15               | 257                           |             | 2,463                       | 16 |
| 17 | Dinette/Common area remodel - doors, windows, countertops, cabinetry |                  |                  |                     |           |                              |                  |                               |             |                             | 17 |
| 18 | (cont.) Flooring, electrical, plywood, paint                         |                  |                  | 2011                | 13,693    | 913                          | 15               | 913                           |             | 8,751                       | 18 |
| 19 | Back-Up Generator                                                    |                  |                  | 2011                | 12,864    | 643                          | 20               | 643                           |             | 6,003                       | 19 |
| 20 | Sprinkler System                                                     |                  |                  | 2012                | 97,800    | 3,912                        | 25               | 3,912                         |             | 35,208                      | 20 |
| 21 | Fire Doors                                                           |                  |                  | 2012                | 9,942     | 663                          | 15               | 663                           |             | 5,855                       | 21 |
| 22 | Oxygen Shed                                                          |                  |                  | 2012                | 1,941     | 194                          | 10               | 194                           |             | 1,634                       | 22 |
| 23 | AC Equipment North Hallway                                           |                  |                  | 2014                | 1,896     | 190                          | 10               | 190                           |             | 1,232                       | 23 |
| 24 | Painting 1 Room, 1/2 North Hall                                      |                  |                  | 2014                | 250       |                              | 5                |                               |             | 250                         | 24 |
| 25 | Therapy Remodel - flooring, painting, & lighting                     |                  |                  | 2015                | 4,045     | 270                          | 15               | 270                           |             | 1,528                       | 25 |
| 26 | Vinyl Sliding Door & Installation                                    |                  |                  | 2015                | 5,325     | 355                          | 15               | 355                           |             | 1,923                       | 26 |
| 27 | Flooring in North Hall Rooms and hallway                             |                  |                  | 2015                | 7,282     | 485                          | 15               | 485                           |             | 2,589                       | 27 |
| 28 | Lightitng, Drywall, Paint and Flooring in Back Hallway               |                  |                  | 2017                | 4,690     | 313                          | 15               | 313                           |             | 1,094                       | 28 |
| 29 | New Countertop and Paint for Nurse Station in South Hall             |                  |                  | 2017                | 2,922     | 195                          | 15               | 195                           |             | 633                         | 29 |
| 30 | Lights, Flooring, Paint, Door Handles, and new Cabinets for          |                  |                  |                     |           |                              |                  |                               |             |                             | 30 |
| 31 | Therapy room                                                         |                  |                  | 2017                | 16,563    | 1,104                        | 15               | 1,104                         |             | 3,771                       | 31 |
| 32 | New Pipes and Plumbing for North Hall Shower                         |                  |                  | 2017                | 2,077     | 139                          | 15               | 139                           |             | 475                         | 32 |
| 33 | Portable Building - Cook Portable Warehouse                          |                  |                  | 2020                | 5,342     | 119                          | 15               | 119                           |             | 119                         | 33 |
| 34 |                                                                      |                  |                  |                     |           |                              |                  |                               |             |                             | 34 |
| 35 |                                                                      |                  |                  |                     |           |                              |                  |                               |             |                             | 35 |
| 36 |                                                                      |                  |                  |                     |           |                              |                  |                               |             |                             | 36 |

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

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

See Page 12A, Line 70 for total  
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Helia Healthcare of Benton

# 0049775

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 | Related Party Allocation - Bridgemark Healthcare, LLC |                  | \$         | \$                        |               | \$                         | \$          | \$                       | 37 |
| 38 | New Office Build Out                                  | 2011             | 6,603      |                           | 20            | 350                        | 350         | 3,305                    | 38 |
| 39 | Conference Room Chair Rail & Paing                    | 2012             | 75         |                           | 5             |                            |             | 75                       | 39 |
| 40 | AC Unit in Server Room                                | 2018             | 512        |                           | 20            | 26                         | 26          | 64                       | 40 |
| 41 |                                                       |                  |            |                           |               |                            |             |                          | 41 |
| 42 |                                                       |                  |            |                           |               |                            |             |                          | 42 |
| 43 |                                                       |                  |            |                           |               |                            |             |                          | 43 |
| 44 |                                                       |                  |            |                           |               |                            |             |                          | 44 |
| 45 |                                                       |                  |            |                           |               |                            |             |                          | 45 |
| 46 |                                                       |                  |            |                           |               |                            |             |                          | 46 |
| 47 |                                                       |                  |            |                           |               |                            |             |                          | 47 |
| 48 |                                                       |                  |            |                           |               |                            |             |                          | 48 |
| 49 |                                                       |                  |            |                           |               |                            |             |                          | 49 |
| 50 |                                                       |                  |            |                           |               |                            |             |                          | 50 |
| 51 | Related Party Allocation - Helia Healthcare           |                  |            |                           |               |                            |             |                          | 51 |
| 52 | Water & Sewer Pipe Installation                       | 2006             | 682        |                           | 20            | 34                         | 34          | 492                      | 52 |
| 53 | Plumbing & Heating Installation                       | 2006             | 817        |                           | 20            | 41                         | 41          | 589                      | 53 |
| 54 | 400 Gal. Water Storage Tank                           | 2016             | 5,551      |                           | 10            | 555                        | 555         | 2,452                    | 54 |
| 55 | AC Compressor at Martin's Catering Building           | 2018             | 897        |                           | 15            | 60                         | 60          | 150                      | 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)                               |                  | \$ 415,949 | \$ 11,200                 |               | \$ 19,133                  | \$ 7,933    | \$ 173,898               | 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<br>Cost  | Current Book<br>Depreciation 2 | Straight Line<br>Depreciation 3 | 4<br>Adjustments | Component<br>Life 5 | Accumulated<br>Depreciation 6 |    |
|----|--------------------------|------------|--------------------------------|---------------------------------|------------------|---------------------|-------------------------------|----|
| 71 | Purchased in Prior Years | \$ 140,657 | \$ 10,985                      | \$ 14,000                       | \$ 3,015         | 3-15                | \$ 76,840                     | 71 |
| 72 | Current Year Purchases   | 21,469     | 2,039                          | 2,364                           | 325              | 3-15                | 2,364                         | 72 |
| 73 | Fully Depreciated Assets | 56,421     |                                |                                 |                  |                     | 56,421                        | 73 |
| 74 |                          |            |                                |                                 |                  |                     |                               | 74 |
| 75 | TOTALS                   | \$ 218,547 | \$ 13,024                      | \$ 16,364                       | \$ 3,340         |                     | \$ 135,625                    | 75 |

D. Vehicle Costs. (See instructions.)\*

|    | 1<br>Use                                    | Model, Make<br>and Year 2 | Year<br>Acquired 3 | 4<br>Cost | Current Book<br>Depreciation 5 | Straight Line<br>Depreciation 6 | 7<br>Adjustments | Life in<br>Years 8 | Accumulated<br>Depreciation 9 |    |
|----|---------------------------------------------|---------------------------|--------------------|-----------|--------------------------------|---------------------------------|------------------|--------------------|-------------------------------|----|
| 76 | Facility                                    | Bus                       | 2011               | \$ 28,821 | \$                             | \$                              | \$               |                    | \$ 28,821                     | 76 |
| 77 | Facility                                    | 2006 Dodge Grand Caravan  | 2019               | 3,518     | 879                            | 879                             |                  | 4                  | 1,099                         | 77 |
| 78 |                                             |                           |                    |           |                                |                                 |                  |                    |                               | 78 |
| 79 | Related Party Allocation - Helia Healthcare |                           | 2006               | 3,183     |                                | 796                             | 796              |                    | 2,665                         | 79 |
| 80 | TOTALS                                      |                           |                    | \$ 35,522 | \$ 879                         | \$ 1,675                        | \$ 796           |                    | \$ 32,585                     | 80 |

E. Summary of Care-Related Assets

|    |                            | 1<br>Reference                                                                                           | 2<br>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) | \$ 671,816  | 81 |
| 82 | Current Book Depreciation  | (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)                 | \$ 25,103   | 82 |
| 83 | Straight Line Depreciation | (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)                 | \$ 37,172   | 83 |
| 84 | Adjustments                | (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)                 | \$ 12,069   | 84 |
| 85 | Accumulated Depreciation   | (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)                 | \$ 342,108  | 85 |

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

|    | 1<br>Description & Year Acquired | 2<br>Cost | Current Book<br>Depreciation 3 | Accumulated<br>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:Section N/A
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<br>Year<br>Constructed | 2<br>Number<br>of Beds | 3<br>Original<br>Lease Date | 4<br>Rental<br>Amount | 5<br>Total Years<br>of Lease | 6<br>Total Years<br>Renewal Option* |   |
|---|--------------------------|--------------------------|------------------------|-----------------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building:       |                          |                        |                             | \$                    |                              |                                     | 3 |
| 4 | Additions                |                          |                        |                             |                       |                              |                                     | 4 |
| 5 | Storage                  |                          |                        |                             | 4,313                 |                              |                                     | 5 |
| 6 | Related Party Allocation |                          |                        |                             | 6,177                 |                              |                                     | 6 |
| 7 | TOTAL                    |                          |                        |                             | \$10,490              |                              |                                     | 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☒ X NO
16. Rental Amount for movable equipment: \$19,010 Description:See Attached Schedule  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

|    | 1<br>Use    | 2<br>Model Year<br>and Make | 3<br>Monthly Lease<br>Payment | 4<br>Rental Expense<br>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 Benton  
Attachment to Schedule XII B  
Equipment Rentals  
12/31/2020

| Description |                                                  |               |
|-------------|--------------------------------------------------|---------------|
| 16A         | Nursing Equipment                                | 10,090        |
| 16B         | Copier Lease                                     | 151           |
| 16C         | Dietary Equipment                                | 464           |
| 16D         | Related Party Allocation - Bridgemark Healthcare | 772           |
| 16E         | Respiratory Equipment                            | 7,533         |
|             |                                                  | <u>19,010</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<br>Line & Column<br>Reference | Staff               |      | Outside Practitioner<br>(other than consultant) |            | Supplies<br>(Actual or<br>Allocated) | Total Units<br>(Column 2 + 4) | Total Cost<br>(Col. 3 + 5 + 6) |    |
|                                                         |                                                                                |                                          | Units of<br>Service | Cost | Units                                           | Cost       |                                      |                               |                                |    |
| 1                                                       | Licensed Occupational Therapist                                                |                                          | hrs                 | \$   |                                                 | \$         | \$                                   |                               | \$                             | 1  |
| 2                                                       | Licensed Speech and Language<br>Development Therapist                          |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 2  |
| 3                                                       | Licensed Recreational Therapist                                                |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 3  |
| 4                                                       | Licensed Physical Therapist                                                    |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 4  |
| 5                                                       | Physician Care                                                                 |                                          | visits              |      |                                                 |            |                                      |                               |                                | 5  |
| 6                                                       | Dental Care                                                                    |                                          | visits              |      |                                                 |            |                                      |                               |                                | 6  |
| 7                                                       | Work Related Program                                                           |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 7  |
| 8                                                       | Habilitation                                                                   |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 8  |
| 9                                                       | Pharmacy                                                                       | 39, 2                                    | # of<br>prescrpts   |      |                                                 |            | 106,155                              |                               | 106,155                        | 9  |
| 10                                                      | Psychological Services<br>(Evaluation and Diagnosis/<br>Behavior Modification) |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 10 |
| 11                                                      | Academic Education                                                             |                                          | hrs                 |      |                                                 |            |                                      |                               |                                | 11 |
| 12                                                      | Other (specify): <u>Wound, Oxy, External</u>                                   | 39, 2                                    |                     |      |                                                 |            | 20,046                               |                               | 20,046                         | 12 |
| 13                                                      | Other (specify): <u>X-Ray, Labs, Therapy</u>                                   | 39, 3                                    |                     |      |                                                 | 431,945    |                                      |                               | 431,945                        | 13 |
| 14                                                      | TOTAL                                                                          |                                          |                     | \$   |                                                 | \$ 431,945 | \$ 126,201                           |                               | \$ 558,146                     | 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            | 2              |    |
|----|----------------------------------------------------------------------------|--------------|----------------|----|
|    |                                                                            | Operating    | After          |    |
|    |                                                                            |              | Consolidation* |    |
|    | <b>A. Current Assets</b>                                                   |              |                |    |
| 1  | Cash on Hand and in Banks                                                  | \$ 5,392     | \$             | 1  |
| 2  | Cash-Patient Deposits                                                      |              |                | 2  |
| 3  | Accounts & Short-Term Notes Receivable-Patients (less allowance (80,000) ) | 572,951      |                | 3  |
| 4  | Supply Inventory (priced at )                                              |              |                | 4  |
| 5  | Short-Term Investments                                                     |              |                | 5  |
| 6  | Prepaid Insurance                                                          |              |                | 6  |
| 7  | Other Prepaid Expenses                                                     | 2,546        |                | 7  |
| 8  | Accounts Receivable (owners or related parties)                            | 7,356,046    |                | 8  |
| 9  | Other(specify): Deposits                                                   | 1,426        |                | 9  |
| 10 | <b>TOTAL Current Assets</b><br>(sum of lines 1 thru 9)                     | \$ 7,938,361 | \$             | 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                                 | 218,778      |                | 15 |
| 16 | Equipment, at Historical Cost                                              | 191,162      |                | 16 |
| 17 | Accumulated Depreciation (book methods)                                    | (210,988)    |                | 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 | <b>TOTAL Long-Term Assets</b><br>(sum of lines 11 thru 23)                 | \$ 198,952   | \$             | 24 |
| 25 | <b>TOTAL ASSETS</b><br>(sum of lines 10 and 24)                            | \$ 8,137,313 | \$             | 25 |

|    |                                                                 | 1            | 2              |    |
|----|-----------------------------------------------------------------|--------------|----------------|----|
|    |                                                                 | Operating    | After          |    |
|    |                                                                 |              | Consolidation* |    |
|    | <b>C. Current Liabilities</b>                                   |              |                |    |
| 26 | Accounts Payable                                                | \$ 306,748   | \$             | 26 |
| 27 | Officer's Accounts Payable                                      |              |                | 27 |
| 28 | Accounts Payable-Patient Deposits                               |              |                | 28 |
| 29 | Short-Term Notes Payable                                        |              |                | 29 |
| 30 | Accrued Salaries Payable                                        | 88,507       |                | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes)             | 2,938        |                | 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 |
|    | <b>Other Current Liabilities(specify):</b>                      |              |                |    |
| 36 | Assessment Tax & N/P Medline                                    | 9,100        |                | 36 |
| 37 | Deferred CARES Funds                                            | 656,460      |                | 37 |
| 38 | <b>TOTAL Current Liabilities</b><br>(sum of lines 26 thru 37)   | \$ 1,063,753 | \$             | 38 |
|    | <b>D. Long-Term Liabilities</b>                                 |              |                |    |
| 39 | Long-Term Notes Payable                                         | 448,084      |                | 39 |
| 40 | Mortgage Payable                                                |              |                | 40 |
| 41 | Bonds Payable                                                   |              |                | 41 |
| 42 | Deferred Compensation                                           |              |                | 42 |
|    | <b>Other Long-Term Liabilities(specify):</b>                    |              |                |    |
| 43 | Rent Payable                                                    | 2,680,000    |                | 43 |
| 44 | Note Payable - Owner                                            | 123,729      |                | 44 |
| 45 | <b>TOTAL Long-Term Liabilities</b><br>(sum of lines 39 thru 44) | \$ 3,251,813 | \$             | 45 |
| 46 | <b>TOTAL LIABILITIES</b><br>(sum of lines 38 and 45)            | \$ 4,315,566 | \$             | 46 |
| 47 | <b>TOTAL EQUITY</b> (page 18, line 24)                          | \$ 3,821,747 | \$             | 47 |
| 48 | <b>TOTAL LIABILITIES AND EQUITY</b><br>(sum of lines 46 and 47) | \$ 8,137,313 | \$             | 48 |

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

|    |                                                              | 1<br>Total   |      |
|----|--------------------------------------------------------------|--------------|------|
| 1  | Balance at Beginning of Year, as Previously Reported         | \$ 3,468,704 | 1    |
| 2  | Restatements (describe):                                     |              | 2    |
| 3  |                                                              |              | 3    |
| 4  |                                                              |              | 4    |
| 5  |                                                              |              | 5    |
| 6  | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ 3,468,704 | 6    |
|    | A. Additions (deductions):                                   |              |      |
| 7  | NET Income (Loss) (from page 19, line 43)                    | 353,043      | 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)             | \$ 353,043   | 17   |
|    | B. Transfers (Itemize):                                      |              |      |
| 18 |                                                              |              | 18   |
| 19 |                                                              |              | 19   |
| 20 |                                                              |              | 20   |
| 21 |                                                              |              | 21   |
| 22 |                                                              |              | 22   |
| 23 | TOTAL Transfers (sum of lines 18-22)                         | \$           | 23   |
| 24 | BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)            | \$ 3,821,747 | 24 * |

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Helia Healthcare of Benton

# 0049775

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       |     |
|-----|-----------------------------------------------------------|--------------|-----|
|     | <b>A. Inpatient Care</b>                                  |              |     |
| 1   | Gross Revenue -- All Levels of Care                       | \$ 4,554,612 | 1   |
| 2   | Discounts and Allowances for all Levels                   | (166,880)    | 2   |
| 3   | <b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>      | \$ 4,387,732 | 3   |
|     | <b>B. Ancillary Revenue</b>                               |              |     |
| 4   | Day Care                                                  |              | 4   |
| 5   | Other Care for Outpatients                                |              | 5   |
| 6   | Therapy                                                   | 131,154      | 6   |
| 7   | Oxygen                                                    | 20,004       | 7   |
| 8   | <b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>        | \$ 151,158   | 8   |
|     | <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                                         |              | 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> | \$           | 23  |
|     | <b>D. Non-Operating Revenue</b>                           |              |     |
| 24  | Contributions                                             |              | 24  |
| 25  | Interest and Other Investment Income***                   | 1,192        | 25  |
| 26  | <b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>   | \$ 1,192     | 26  |
|     | <b>E. Other Revenue (specify):****</b>                    |              |     |
| 27  | <b>Settlement Income (Insurance, Legal, Etc.)</b>         |              | 27  |
| 28  | <b>Vending Income</b>                                     | 916          | 28  |
| 28a | <b>Miscellaneous Income</b>                               | 2,864        | 28a |
| 29  | <b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>      | \$ 3,780     | 29  |
| 30  | <b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>   | \$ 4,543,862 | 30  |

2

|    | II. Expenses                                                   | Amount       |    |
|----|----------------------------------------------------------------|--------------|----|
|    | <b>A. Operating Expenses</b>                                   |              |    |
| 31 | General Services                                               | 792,529      | 31 |
| 32 | Health Care                                                    | 1,451,488    | 32 |
| 33 | General Administration                                         | 834,873      | 33 |
|    | <b>B. Capital Expense</b>                                      |              |    |
| 34 | Ownership                                                      | 401,595      | 34 |
|    | <b>C. Ancillary Expense</b>                                    |              |    |
| 35 | Special Cost Centers                                           | 558,145      | 35 |
| 36 | Provider Participation Fee                                     | 152,189      | 36 |
|    | <b>D. Other Expenses (specify):</b>                            |              |    |
| 37 |                                                                |              | 37 |
| 38 |                                                                |              | 38 |
| 39 |                                                                |              | 39 |
| 40 | <b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>               | \$ 4,190,819 | 40 |
| 41 | <b>Income before Income Taxes (line 30 minus line 40)**</b>    | 353,043      | 41 |
| 42 | <b>Income Taxes</b>                                            |              | 42 |
| 43 | <b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b> | \$ 353,043   | 43 |

|    | III. Net Inpatient Revenue detailed by Payer Source                   |              |    |
|----|-----------------------------------------------------------------------|--------------|----|
| 44 | Medicaid - Net Inpatient Revenue                                      | \$ 1,647,879 | 44 |
| 45 | Private Pay - Net Inpatient Revenue                                   | 749,949      | 45 |
| 46 | Medicare - Net Inpatient Revenue                                      | 1,876,769    | 46 |
| 47 | Other-(specify) <b>Insurance</b>                                      | 101,934      | 47 |
| 48 | Other-(specify) <b>Hospice</b>                                        | 11,201       | 48 |
| 49 | <b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b> | \$ 4,387,732 | 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           | 2,272                     | 2,369                      | \$ 84,013                              | \$ 35.46            | 1  |
| 2  | Assistant Director of Nursing |                           |                            |                                        |                     | 2  |
| 3  | Registered Nurses             | 9,381                     | 10,143                     | 311,478                                | 30.71               | 3  |
| 4  | Licensed Practical Nurses     | 9,797                     | 10,288                     | 265,226                                | 25.78               | 4  |
| 5  | CNAs & Orderlies              | 38,046                    | 39,718                     | 517,314                                | 13.02               | 5  |
| 6  | CNA Trainees                  |                           |                            |                                        |                     | 6  |
| 7  | Licensed Therapist            |                           |                            |                                        |                     | 7  |
| 8  | Rehab/Therapy Aides           |                           |                            |                                        |                     | 8  |
| 9  | Activity Director             |                           |                            |                                        |                     | 9  |
| 10 | Activity Assistants           | 4,149                     | 4,364                      | 57,866                                 | 13.26               | 10 |
| 11 | Social Service Workers        | 1,885                     | 2,140                      | 46,133                                 | 21.56               | 11 |
| 12 | Dietician                     |                           |                            |                                        |                     | 12 |
| 13 | Food Service Supervisor       | 2,011                     | 2,138                      | 33,541                                 | 15.69               | 13 |
| 14 | Head Cook                     |                           |                            |                                        |                     | 14 |
| 15 | Cook Helpers/Assistants       | 4,304                     | 4,660                      | 53,806                                 | 11.55               | 15 |
| 16 | Dishwashers                   |                           |                            |                                        |                     | 16 |
| 17 | Maintenance Workers           | 840                       | 903                        | 11,332                                 | 12.55               | 17 |
| 18 | Housekeepers                  | 7,848                     | 8,592                      | 118,990                                | 13.85               | 18 |
| 19 | Laundry                       | 1,109                     | 1,206                      | 15,815                                 | 13.11               | 19 |
| 20 | Administrator                 | 2,012                     | 2,222                      | 101,359                                | 45.62               | 20 |
| 21 | Assistant Administrator       |                           |                            |                                        |                     | 21 |
| 22 | Other Administrative          |                           |                            |                                        |                     | 22 |
| 23 | Office Manager                | 2,060                     | 2,382                      | 65,722                                 | 27.59               | 23 |
| 24 | Clerical                      |                           |                            |                                        |                     | 24 |
| 25 | Vocational Instruction        |                           |                            |                                        |                     | 25 |
| 26 | Academic Instruction          |                           |                            |                                        |                     | 26 |
| 27 | Medical Director              |                           |                            |                                        |                     | 27 |
| 28 | Qualified MR Prof. (QMRP)     |                           |                            |                                        |                     | 28 |
| 29 | Resident Services Coordinator |                           |                            |                                        |                     | 29 |
| 30 | Habilitation Aides (DD Homes) |                           |                            |                                        |                     | 30 |
| 31 | Medical Records               | 1,863                     | 1,971                      | 33,500                                 | 17.00               | 31 |
| 32 | Other Health Care(specify)    |                           |                            |                                        |                     | 32 |
| 33 | Other(specify)                |                           |                            |                                        |                     | 33 |
| 34 | TOTAL (lines 1 - 33)          | 87,577                    | 93,096                     | \$ 1,716,095 *                         | \$ 18.43            | 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              |                               | \$                                         |                                    | 35 |
| 36 | Medical Director                |                               | 18,890                                     | 9, 3                               | 36 |
| 37 | Medical Records Consultant      |                               | 2,129                                      | 10, 3                              | 37 |
| 38 | Nurse Consultant                |                               |                                            |                                    | 38 |
| 39 | Pharmacist Consultant           |                               | 1,806                                      | 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             |                               | 905                                        | 11, 3                              | 44 |
| 45 | Social Service Consultant       |                               | 1,886                                      | 12, 3                              | 45 |
| 46 | Other(specify)                  |                               |                                            |                                    | 46 |
| 47 |                                 |                               |                                            |                                    | 47 |
| 48 |                                 |                               |                                            |                                    | 48 |
| 49 | TOTAL (lines 35 - 48)           |                               | \$ 25,616                                  |                                    | 49 |

C. CONTRACT NURSES

|    |                                  | 1                             | 2                    | 3                                  |    |
|----|----------------------------------|-------------------------------|----------------------|------------------------------------|----|
|    |                                  | Number of Hrs. Paid & Accrued | Total Contract Wages | Schedule V Line & Column Reference |    |
| 50 | Registered Nurses                | 95                            | \$ 4,929             | 10, 3                              | 50 |
| 51 | Licensed Practical Nurses        |                               |                      |                                    | 51 |
| 52 | Certified Nurse Assistants/Aides |                               |                      |                                    | 52 |
| 53 | TOTAL (lines 50 - 52)            | 95                            | \$ 4,929             |                                    | 53 |

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

# 0049775

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

Facility Name & ID Number

Helia Healthcare of Benton

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Loretta Ellis

Administrator

0

\$ 101,359

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

(List each licensed administrator separately.)

\$ 101,359

B. Administrative - Other

Description

Amount

Bridgemark Healthcare LLC - Management Fee

\$ 234,000

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

(Attach a copy of any management service agreement)

\$ 234,000

C. Professional Services

Vendor/Payee

Type

Amount

Nationwide Trust

401k Admin

\$ 978

Personnel Planners

Unemployment Consulting

2,216

C.J. Schlosser & Company, LLC

Accounting Services

4,000

Pantegra

401k Admin

3,100

Paycom Payroll, LLC

Payroll Processing

15,076

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

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

\$ 25,370

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 10,605

Unemployment Compensation Insurance

10,610

FICA Taxes

129,572

Employee Health Insurance

28,882

Employee Meals

Illinois Municipal Retirement Fund (IMRF)\*

401k Match

4,102

Other Employee Insurance

(716)

Employee Benefits

405

Related Party Allocation - Bridgemark

11,474

Related Party Allocation - Helia Healthcare

19,596

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

\$ 214,530

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

Description

Line #

Amount

Section N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

4,506

Health Care Worker Background Check

1,895

(Indicate # of checks performed )

Patient Background Checks

Dues & Subscriptions

6,414

IHCA Dues

4,334

Miscellaneous Licenses & Fees

684

Advertising

39,120

Related Party Allocations

1,376

Less: Public Relations Expense

( )

Non-allowable advertising

(39,120)

Yellow page advertising

( )

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

\$ 21,199

G. Schedule of Travel and Seminar\*\*

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

475

Related Party Allocation - Bridgemark

1,730

Entertainment Expense

( )

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

TOTAL

\$ 2,205

\* 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 \$4,334
- (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. \$ 8,754 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. \$ 152,189  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

## SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 916
- (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? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.