

		FOR BHF USE					

LL1

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: 0048587

Facility Name: Helia Southbelt Healthcare

Address: 101 South Belt West Belleville 62220
Number City Zip Code

County: St Clair

Telephone Number: (618) 277-7700 Fax # (618) 355-4050

HFS ID Number:

Date of Initial License for Current Owners: 10/02/08

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ 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) (Date)

(Type or Print Name) Jason Mills

(Title) Chief Financial Officer

Paid
Preparer

(Signed) See Accountant's Preparation Report (Date)

(Print Name and Title) Cindy A. Tefteller
Partner

(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL

(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare

0048587 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>156</u>	Skilled (SNF)	<u>156</u>	<u>57,096</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>57,096</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,794</u>	<u>2,081</u>	<u>10,096</u>	<u>32,971</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,794</u>	<u>2,081</u>	<u>10,096</u>	<u>32,971</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.75%

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 10/02/08

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

YES ☒ Date 10/02/08 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 156 and days of care provided 6,048

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	254,010	38,097	24,466	316,573		316,573		316,573			1
2	Food Purchase		244,589		244,589		244,589	(76)	244,513			2
3	Housekeeping	226,050	38,348	5,972	270,370		270,370		270,370			3
4	Laundry	72,529	20,959		93,488		93,488		93,488			4
5	Heat and Other Utilities			139,056	139,056		139,056	(20,584)	118,472			5
6	Maintenance	50,149	12,786	55,630	118,565		118,565		118,565			6
7	Other (specify):*											7
8	TOTAL General Services	602,738	354,779	225,124	1,182,641		1,182,641	(20,660)	1,161,981			8
	B. Health Care and Programs											
9	Medical Director			43,575	43,575		43,575		43,575			9
10	Nursing and Medical Records	2,697,397	193,761	109,017	3,000,175		3,000,175	35,303	3,035,478			10
10a	Therapy		905		905		905		905			10a
11	Activities	87,022	11,537	2,620	101,179		101,179		101,179			11
12	Social Services	133,299		2,117	135,416		135,416		135,416			12
13	CNA Training											13
14	Program Transportation			12,596	12,596		12,596		12,596			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,917,718	206,203	169,925	3,293,846		3,293,846	35,303	3,329,149			16
	C. General Administration											
17	Administrative	113,850		445,700	559,550		559,550	(412,631)	146,919			17
18	Directors Fees											18
19	Professional Services			146,737	146,737		146,737	10,737	157,474			19
20	Dues, Fees, Subscriptions & Promotions			73,395	73,395		73,395	(40,916)	32,479			20
21	Clerical & General Office Expenses	218,220	28,638	152,399	399,257		399,257	163,149	562,406			21
22	Employee Benefits & Payroll Taxes			462,186	462,186		462,186	19,202	481,388			22
23	Inservice Training & Education											23
24	Travel and Seminar			6	6		6	2,895	2,901			24
25	Other Admin. Staff Transportation			3,932	3,932		3,932	4,133	8,065			25
26	Insurance-Prop.Liab.Malpractice			512,549	512,549		512,549	27,841	540,390			26
27	Other (specify):*											27
28	TOTAL General Administration	332,070	28,638	1,796,904	2,157,612		2,157,612	(225,590)	1,932,022			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,852,526	589,620	2,191,953	6,634,099		6,634,099	(210,947)	6,423,152			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			36,707	36,707		36,707	4,700	41,407			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90,741	90,741		90,741	(641)	90,100			32
33	Real Estate Taxes			75,614	75,614		75,614	51	75,665			33
34	Rent-Facility & Grounds			550,622	550,622		550,622	8,693	559,315			34
35	Rent-Equipment & Vehicles			31,601	31,601		31,601	1,292	32,893			35
36	Other (specify):*											36
37	TOTAL Ownership			785,285	785,285		785,285	14,095	799,380			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		310,141	1,198,542	1,508,683		1,508,683		1,508,683			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			263,338	263,338		263,338		263,338			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		310,141	1,461,880	1,772,021		1,772,021		1,772,021			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,852,526	899,761	4,439,118	9,191,405		9,191,405	(196,852)	8,994,553			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 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(21,240)	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	(641)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,409)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(33,494)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,557)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,417)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(123,435)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (123,435)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (196,852)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	\$ (5,336)	20	1
2	To Offset Medical Records Income	(1,385)	10	2
3	To Eliminate Lobbying & PAC Dues	(3,836)	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	(10,557)		49

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller		Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcar	St. Ann, MO	Management Co
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Helia Healthcare Serv.	Benton, IL	Laundry, Maint
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Ann, MO	Human Resources
		Helia Healthcare of Belleville	Belleville, IL	Palladian Management	O'Fallon, IL	Management Co
		Helia Healthcare of Olney	Olney, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Asstd Liv/MemCare
				Palladian Taylorville,	Taylorville, IL	Assisted Living

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 656	\$ 656	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	36,688	36,688	2
3	V	17	Management Fees	445,700	Bridgemark Healthcare, LLC	100.00%	33,069	(412,631)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	10,737	10,737	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,750	1,750	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	170,558	170,558	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	19,202	19,202	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,895	2,895	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,133	4,133	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	27,841	27,841	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,700	4,700	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	51	51	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	8,693	8,693	13
14	Total			\$ 445,700			\$ 320,973	\$ * (124,727)	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	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 1,292	\$ 1,292	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 1,292	\$ * 1,292	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 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6			Helia Healthcare of Effingham	Effingham, IL				6
7			Helia Healthcare of Salem	Salem, IL				7
8			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				8
9			Helia Richland Healthcare, LLC	Olney, IL				9
10			Helia Healthcare of Newton, LLC	Newton, IL				10
11			Palladian Taylorville SNF, LLC	Taylorville, IL				11
12			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				12
13			Palladian Aviston SNF, LLC	Aviston, IL				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	373,359	4.07	8.14	Distribution	\$ 33,069	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	\$ 33,069		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

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	89,195	6
7	Omnicare		X	Vendor Note							7.5000	174	7
8	Medline		X	Vendor Note		11/15/19					8.0000	1,372	8
9	TOTAL Facility Related						\$					\$ 90,741	9
	B. Non-Facility Related*												
10	Interest Income Offset											(641)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (641)	14
15	TOTALS (line 9+line14)						\$					\$ 90,100	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 Southbelt Healthcare COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048587

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-28.0-403-066	LOT/SEC-58PT LT 58	\$ 565.14	\$ 565.14
2. 08-28.0-403-056	LOT/SEC-59PT LOTS 57 & 58	\$ 5,501.62	\$ 5,501.62
3. 08-28.0-403-004	LOT/SEC-4 PT LYG S OF RICH CR	\$	\$
4. 08-28.0-403-003	LOT/SEC-3 PT LYG S OF RICH CR	\$ 54.70	\$ 54.70
5. 08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	\$ 112.20	\$ 112.20
6. 08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	\$ 362.30	\$ 362.30
7. 08-28.0-403-055	LOT/SEC-58 PT LTS 57 & 58	\$ 69,642.16	\$ 69,642.16
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 76,238.12	\$ 76,238.12

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: 51,562

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' 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 Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire Department Connection			2008	1,685		10			1,685	9
10	Metro Lock & Security & Fire Alarm Door Holders			2009	2,614	95	10	95		2,275	10
11	Water Heater			2009	3,443		10			3,443	11
12	Kitchen Floor			2009	1,799		10			1,799	12
13	New Compressor			2009	1,647	110	15	110		1,254	13
14	Commercial Disposal			2010	1,272		5			1,272	14
15	P-Tec Heat Pump			2010	1,964		10			1,964	15
16	Replace Rooftop AC Unit			2010	4,481	37	10	37		4,481	16
17	2 Victorian Fire Doors			2011	2,500	167	15	167		1,542	17
18	22 Fire Doors			2011	6,688	446	15	446		4,124	18
19	Cabinets for New Therapy Room			2012	3,759	251	15	251		2,026	19
20	PTAC Unit			2012	956		5			956	20
21	5x5 PCS Gate			2012	630		5			630	21
22	Transformer, Power Supply			2012	2,202	220	10	220		1,909	22
23	Hot Water Storage Tank			2012	1,800	90	20	90		773	23
24	New Compressor & Rooftop Unit			2012	13,089	873	15	873		7,417	24
25	100 Gallon Natural Gas Water Heater			2012	3,197	320	10	320		2,584	25
26	4 PTAC Heat Pumps			2012	2,601		5			2,601	26
27	Arch Wing - Tear out old walls & rebuild new patient rooms, therapy room										27
28	(cont.) dining area, lounge area & nurse office, drywall, paint, boarders labor										28
29	(cont.) doors, windows, electrical, lighting fixtures			2012	159,472	7,974	20	7,974		64,453	29
30	Power Metal Door			2012	5,530	276	20	276		2,235	30
31	Cabinets for New Med Room			2012	2,422	161	15	161		1,305	31
32	New Nurses' Station			2012	14,775	985	15	985		7,962	32
33	Relocated Fire Panel			2012	3,389	339	10	339		2,739	33
34	Build 2 new shower rooms - Tile, Fixtures, Walls, Labor			2012	17,907	895	20	895		7,237	34
35	Flooring for new ARCH Wing			2012	23,558	2,356	10	2,356		19,043	35
36	Building Sign			2013	8,449	845	10	845		6,478	36

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

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

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

Facility Name & ID Number Helia Southbelt Healthcare

0048587

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	Nurses Station ARCH Unit	2013	\$ 5,132	\$ 342	15	\$ 342	\$	\$ 2,623	37
38	Carrier Heat Pump & Fan Oil	2013	7,236	724	10	724		5,246	38
39	Amana PTAC	2013	1,183		5			1,183	39
40	Replace Heat Exchanger	2014	1,902		5			1,902	40
41	Amana PTAC	2014	2,522		5			2,522	41
42	Cabling for New Call System	2014	1,330		5			1,330	42
43	Installation of annunciator panel for all wings	2014	4,438	444	10	444		3,013	43
44	Roof Repair	2014	12,880	1,288	10	1,288		8,268	44
45	500 Hall dining room drywall & paint	2014	1,715	172	10	172		1,072	45
46	Vinyl Plank Floor for 200 Hall	2015	3,485	348	10	348		1,917	46
47	Roof Repairs from Storm Damage	2017	3,500	350	10	350		1,313	47
48	Therapy Room Remodel - Cabinets, Vinyl Floor, Entryway Work	2018	6,823	455	15	455		985	48
49	PTAC Heat Pump, 9000 Cooling BTU	2018	1,414	283	5	283		730	49
50	Roofing Membrane	2019	8,895	889	10	889		1,779	50
51	Nurse Call Station Replacement	2019	2,684	268	10	268		470	51
52	Amana Digismart Heat Pump	2019	3,878	388	10	388		743	52
53	2 HD 2X4'6" Sign Foam Panels w/Painted Graphics	2020	2,724	113	10	113		113	53
54									54
55	Related Part Allocation - Bridgemark Healthcare								55
56	New Office Build Out	2011	11,051		20	585	585	5,532	56
57	Conference Rm Chair Rail & Paint	2012	125		5			125	57
58	AC Unit in Server Room	2018	857		20	43	43	107	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)		\$ 375,603	\$ 22,504		\$ 23,132	\$ 628	\$ 195,160	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$118,233	\$8,936	\$12,465	\$3,529		\$68,565	71
72	Current Year Purchases	22,844	1,601	2,144	543		2,144	72
73	Fully Depreciated Assets	30,369					30,369	73
74								74
75	TOTALS	\$171,446	\$10,537	\$14,609	\$4,072		\$101,078	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Van		2017	\$7,500	\$1,875	\$1,875		4	\$6,875
77	2005 Chevy Truck		2017	7,164	1,791	1,791		4	6,567
78									
79									
80	TOTALS			\$14,664	\$3,666	\$3,666			\$13,442

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	561,713
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	36,707
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	41,407
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	4,700
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	309,680

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	Section N/A	\$	\$	
87				
88				
89				
90				
91	TOTALS	\$	\$	

G. Construction-in-Progress		
	Description	Cost
92	Section N/A	\$
93		
94		
95		\$

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:OMG Belleville Belt Property
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		156	5/7/18	\$550,622			3
4	Additions							4
5								5
6	Related Party Allocations				8,693			6
7	TOTAL		156		\$559,315			7

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

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

N/A

.
- N/A

9. Option to Buy:

☐ YES

☒ NO

Terms:*

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

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO
16. Rental Amount for movable equipment:\$32,893Description:See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Description		
16A	Specialty Bed Rental	19,662
16B	Copier Lease	11,745
16C	Related Party Allocation - Bridgemark Healthcare	1,292
16E	Storage	194
		<u>32,893</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				905		905	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				260,957		260,957	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, External</u>	39, 2					49,184		49,184	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				1,198,542			1,198,542	13
14	TOTAL			\$		\$ 1,198,542	\$ 311,046		\$ 1,509,588	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,515	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (60,000))	687,361		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,093		6
7	Other Prepaid Expenses	1,481		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 731,450	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	363,570		15
16	Equipment, at Historical Cost	166,379		16
17	Accumulated Depreciation (book methods)	(292,127)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 237,822	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 969,272	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 351,495	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	977,204		29
30	Accrued Salaries Payable	236,943		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,343		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	11,758		36
37	Deferred CARES Funds	400,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,983,743	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Parties	3,499,274		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,499,274	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,483,017	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,513,745)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 969,272	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,362,816)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,362,816)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(150,929)	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)	\$ (150,929)	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)	\$ (4,513,745)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare

0048587

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,466,121	1
2	Discounts and Allowances for all Levels	(587,773)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,878,348	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	451,925	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 451,925	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	641	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 641	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	CARES Funds	682,997	28
28a	Other/Medical Records	26,565	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 709,562	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,040,476	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,182,641	31
32	Health Care	3,293,846	32
33	General Administration	2,157,612	33
	B. Capital Expense		
34	Ownership	785,285	34
	C. Ancillary Expense		
35	Special Cost Centers	1,508,683	35
36	Provider Participation Fee	263,338	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,191,405	40
41	Income before Income Taxes (line 30 minus line 40)**	(150,929)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (150,929)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,461,023	44
45	Private Pay - Net Inpatient Revenue	431,455	45
46	Medicare - Net Inpatient Revenue	2,668,517	46
47	Other-(specify) Hospice	286,325	47
48	Other-(specify) Insurance	1,031,028	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,878,348	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	978	1,049	\$ 50,630	\$ 48.27	1
2	Assistant Director of Nursing	1,938	2,102	90,431	43.02	2
3	Registered Nurses	10,447	11,240	410,503	36.52	3
4	Licensed Practical Nurses	24,380	26,484	856,403	32.34	4
5	CNAs & Orderlies	63,993	68,463	1,219,102	17.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,198	4,769	87,022	18.25	10
11	Social Service Workers	5,536	6,174	133,299	21.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,476	17,798	254,010	14.27	15
16	Dishwashers					16
17	Maintenance Workers	1,835	2,161	50,149	23.21	17
18	Housekeepers	12,824	14,524	226,050	15.56	18
19	Laundry	4,982	5,323	72,529	13.63	19
20	Administrator	2,071	2,176	113,850	52.32	20
21	Assistant Administrator					21
22	Other Administrative	6,500	7,450	218,220	29.29	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,502	2,682	70,328	26.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,660	172,395	\$ 3,852,526 *	\$ 22.35	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 24,466	1, 3	35
36	Medical Director		43,575	9, 3	36
37	Medical Records Consultant		1	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,774	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,620	11, 3	44
45	Social Service Consultant		2,117	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 85,553		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	153	\$ 8,232	10, 3	50
51	Licensed Practical Nurses	554	25,334	10, 3	51
52	Certified Nurse Assistants/Aides	2,342	62,665	10, 3	52
53	TOTAL (lines 50 - 52)	3,049	\$ 96,231		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Christine Warcup	Administrator	0	\$ 113,850	Workers' Compensation Insurance		\$ 74,308	IDPH License Fee	\$	
				Unemployment Compensation Insurance		16,840	Advertising: Employee Recruitment	11,920	
				FICA Taxes		292,011	Health Care Worker Background Check	2,113	
				Employee Health Insurance		62,945	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising	33,494	
				401(k) Match		11,101	Dues & Subscriptions	6,778	
				Employee Benefits		4,981	Miscellaneous Licenses & Fees	1,773	
TOTAL (agree to Schedule V, line 17, col. 1)							IHCA Dues	8,145	
(List each licensed administrator separately.)			\$ 113,850				Related Party Allocation - Bridgemark	1,750	
B. Administrative - Other				Related Party Allocation - Bridgemark		19,202	Less: Public Relations Expense	()	
Description			Amount				Non-allowable advertising	(33,494)	
Bridgemark Healthcare, LLC - Management Fees			\$ 445,700				Yellow page advertising	()	
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 32,479		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 445,700	TOTAL (agree to Schedule V, line 22, col.8)			\$ 481,388		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount	Section N/A		\$	Out-of-State Travel	\$	
Personnel Planners	Unemployment Consultant		\$ 2,291						
Sandberg Phoenix Von Gontard	Legal Fees		42,207						
Nationwide Trust	401(k) Admin		978				In-State Travel	6	
Much Shelist	Legal Fees		283						
Hamlin & Burton Liability Managem	Legal Fees		48,805						
Stein Law Offices	Legal Fees		1,055						
C.J. Schlosser & Company, LLC	Accounting Services		4,000				Seminar Expense		
Hepler Broom Law Firm	Legal Fees		206						
O'Halloran Kosoff Geitner & Cook, I	Legal Fees		16,382				Related Party Allocation - Bridgemark	2,895	
Pantegra	401(k) Admin		3,100						
Paycom	Payroll Processing		27,430				Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL		
(For legal fee disclosure, see page 39 of instructions)			\$ 146,737				\$ 2,901		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IHCA \$8,145

(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.

\$ 31,535

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.

\$ 263,338

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

Yes

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

No

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

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

\$ None

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A

(16) Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$ N/A

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

N/A

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

No

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

\$ N/A

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

No

Firm Name:

N/A

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

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

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

SEE ACCOUNTANTS' PREPARATION REPORT