

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0050310</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Hillside Rehab & Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1308 Game Farm Road</u> <u>Yorkville</u> <u>60560</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Kendall</u>			
Telephone Number: <u>(630) 553-5811</u> Fax # <u>(630) 553-2740</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>01/15/09</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Cindy A. Tefteller</u>			
Telephone Number: <u>(618) 465-7717</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Jason Mills</u>	
		(Title) <u>Chief Financial Officer</u>	
		(Signed) <u>See Accountant's Preparation Report</u> (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u>	
		(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u>	
		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
		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 Hillside Rehab & Care Center

0050310 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>79</u>	Skilled (SNF)	<u>79</u>	<u>28,914</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>79</u>	TOTALS	<u>79</u>	<u>28,914</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>10,100</u>	<u>1,395</u>	<u>3,586</u>	<u>15,081</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>10,100</u>	<u>1,395</u>	<u>3,586</u>	<u>15,081</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.16%

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 1/15/09

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

YES ☒ Date 1/05/09 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 79 and days of care provided 2,542

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 Hillside Rehab & Care Center # 0050310 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	156,035	8,231	9,955	174,221		174,221		174,221			1
2	Food Purchase		86,706		86,706		86,706	(40)	86,666			2
3	Housekeeping	121,500	53,581	5,325	180,406		180,406		180,406			3
4	Laundry		2,022	111,126	113,148		113,148		113,148			4
5	Heat and Other Utilities			62,831	62,831		62,831	(8,124)	54,707			5
6	Maintenance	49,240	10,593	43,536	103,369		103,369		103,369			6
7	Other (specify):*											7
8	TOTAL General Services	326,775	161,133	232,773	720,681		720,681	(8,164)	712,517			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,229,968	106,193	138,276	1,474,437		1,474,437	16,508	1,490,945			10
10a	Therapy		255		255		255		255			10a
11	Activities	53,944	789	150	54,883		54,883		54,883			11
12	Social Services	42,639		455	43,094		43,094		43,094			12
13	CNA Training											13
14	Program Transportation			8,707	8,707		8,707		8,707			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,326,551	107,237	155,988	1,589,776		1,589,776	16,508	1,606,284			16
	C. General Administration											
17	Administrative	115,373		218,200	333,573		333,573	(203,074)	130,499			17
18	Directors Fees											18
19	Professional Services			40,080	40,080		40,080	4,911	44,991			19
20	Dues, Fees, Subscriptions & Promotions			57,017	57,017		57,017	(33,310)	23,707			20
21	Clerical & General Office Expenses	84,717	16,129	130,133	230,979		230,979	74,960	305,939			21
22	Employee Benefits & Payroll Taxes			151,402	151,402		151,402	68,142	219,544			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,672	2,672		2,672	1,324	3,996			24
25	Other Admin. Staff Transportation			1,495	1,495		1,495	1,890	3,385			25
26	Insurance-Prop.Liab.Malpractice			411,403	411,403		411,403	12,734	424,137			26
27	Other (specify):*											27
28	TOTAL General Administration	200,090	16,129	1,012,402	1,228,621		1,228,621	(72,423)	1,156,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,853,416	284,499	1,401,163	3,539,078		3,539,078	(64,079)	3,474,999			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			31,585	31,585		31,585	2,150	33,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,579	10,579		10,579	(365)	10,214			32
33	Real Estate Taxes			63,600	63,600		63,600	23	63,623			33
34	Rent-Facility & Grounds			342,292	342,292		342,292	3,976	346,268			34
35	Rent-Equipment & Vehicles			63,241	63,241		63,241	591	63,832			35
36	Other (specify):*											36
37	TOTAL Ownership			511,297	511,297		511,297	6,375	517,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,464	435,492	553,956		553,956		553,956			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			122,096	122,096		122,096		122,096			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		118,464	557,588	676,052		676,052		676,052			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,853,416	402,963	2,470,048	4,726,427		4,726,427	(57,704)	4,668,723			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	(8,424)	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	(365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(40)	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	(445)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,054)	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	(29,280)	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	54,700	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 13,092		\$	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)	(70,796)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (70,796)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (57,704)		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	\$ (4,434)	20	1
2	To Offset Medical Records Income	(273)	10	2
3	To Eliminate Lobbying & PAC Dues	(1,942)	20	3
4	To Add 2020 IDPH License Paid in 2019	1,990	20	4
5	W/C retro adjustment related to prior years	59,359	22	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
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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	54,700		49

Facility Name & ID Number Hillside Rehab & Care Center# 0050310Report 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.
		Helia Healthcare of Energy	Energy, IL	Helia Healthcare Serv	Benton, IL	Laundry, Maint.
		Helia Healthcare of Olney	Olney, IL	Bridgemark Employee	St. Ann, MO	Human Resources
		Helia Healthcare of Belleville	Belleville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Palladian Management	O'Fallon, IL	Management Co.
		Helia Southbelt Healthcare	Belleville, IL	Palladian Taylorville A	Taylorville, IL	Assissted Living
		Helia Healthcare of Jerseyville	Jerseyville, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Assissted 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%	\$ 300	\$ 300	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	16,781	16,781	2
3	V	17	Management Fees	218,200	Bridgemark Healthcare, LLC	100.00%	15,126	(203,074)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	4,911	4,911	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	801	801	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	78,014	78,014	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	8,783	8,783	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	1,324	1,324	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	1,890	1,890	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	12,734	12,734	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,150	2,150	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	23	23	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	3,976	3,976	13
14	Total			\$ 218,200			\$ 146,813	\$ * (71,387)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment	\$	Bridgemark Healthcare, LLC	100.00%	\$ 591	\$ 591	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			\$			\$ 591	\$ * 591	39

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

Facility Name & ID Number

Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Healthcare of Newton, LLC	Newton, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Effingham	Effingham, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				7
8			Helia Richland Healthcare, LLC	Olney, IL				8
9			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 Hillside Rehab & Care Center # 0050310 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	391,302	1.86	3.72	Distribution	\$ 15,126	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	\$ 15,126		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

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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 Bridgemark Healthcare, LLC
Street Address 500 NW Plaza Dr., Suite 712
City / State / Zip Code St. Ann, MO 63074
Phone Number (314) 431-0511
Fax Number (314) 754-9176

	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	5	Utilities	Resident Days	405,225	17	\$ 8,060	\$	15,081	\$ 300	1
2	10	Nursing & Medical Supplies	Resident Days	405,225	17	450,909	450,909	15,081	16,781	2
3	17	Owner's Compensation	Resident Days	405,225	17	406,428		15,081	15,126	3
4	19	Professional Fees	Resident Days	405,225	17	131,963		15,081	4,911	4
5	20	Dues, Subscriptions	Resident Days	405,225	17	21,510		15,081	801	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	15,081	61,878	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		15,081	16,136	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	405,225	17	235,995		15,081	8,783	8
9	24	Seminars	Resident Days	405,225	17	35,584		15,081	1,324	9
10	25	Admin Staff Travel	Resident Days	405,225	17	50,795		15,081	1,890	10
11	26	Insurance	Resident Days	405,225	17	342,172		15,081	12,734	11
12	30	Depreciation	Resident Days	405,225	17	57,762		15,081	2,150	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		15,081	23	13
14	34	Building Rent	Resident Days	405,225	17	97,672		15,081	3,635	14
15	34	Rental - Storage Unit	Resident Days	405,225	17	9,163		15,081	341	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		15,081	591	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,960,735	\$ 2,113,564		\$ 147,404	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	9,543	6	
7	HFS		X			5/1/19						421	7	
8	Medline		X	Vendor Note		11/15/19					8.0000	615	8	
9	TOTAL Facility Related						\$		\$			\$ 10,579	9	
	B. Non-Facility Related*													
10	Interest Income Offset											(365)	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$ (365)	14	
15	TOTALS (line 9+line14)							\$		\$			\$ 10,214	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	63,600 2
3. Under or (over) accrual (line 2 minus line 1).				\$	63,600 3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	63,600 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	78,693	8	
		2016	66,805	9	
		2017	64,484	10	
		2018	62,729	11	
		2019	62,155	12	
63,600 Line 7, Real Estate tax portion of the lease payment					
23 Related Party Allocation - Bridgemark					
63,623 Total Schedule V, Line 33					
		FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019 \$				13
14	PLUS APPEAL COST FROM LINE 5 \$				14
15	LESS REFUND FROM LINE 6 \$				15
16	AMOUNT TO USE FOR RATE CALCULATION \$				16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillside Rehab & Care Center COUNTY Kendall

FACILITY IDPH LICENSE NUMBER 0050310

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. 02-29-278-019	Lot 1 Unit 13 Countryside Sub	\$ 50,653.74	\$ 50,653.74
2. 02-29-278-020	Sec 29-37-7	\$ 7,843.02	\$ 7,843.02
3. 02-29-278-018	Lot 12 Unit 1 & Lot 16 Unit 2	\$ 3,658.40	\$ 3,658.40
4.	Countryside Sub	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 62,155.16	\$ 62,155.16

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: 19,390

B. General Construction Type: ExteriorMasonryFrameBrickNumber of Stories1

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	Therapy Door			2009	1,630	109	15	109		1,259	9
10	Wallcovering, Shower Room Remodel, Nurses Station, & Entryway			2009	15,951	1,063	15	1,063		11,963	10
11	Concrete			2009	3,500	233	15	233		2,586	11
12	Hallway Wing 1- Paint, Crown Molding			2010	5,752	383	15	383		4,186	12
13	Oakwell cabinets for nurses station			2010	1,163	77	15	77		840	13
14	Reception Area- Countertop, Oakwork, Drywall			2010	5,127	342	15	342		3,646	14
15	Shower Room W1 Heater, Fire System Installation			2010	2,855	190	15	190		2,030	15
16	Shower Room W1 Heater, Fire System Installation			2010	2,854	190	15	190		2,030	16
17	4 Ton A/C Unit & Install			2010	3,155	132	10	132		3,155	17
18	Concrete Work (Drainage: W1,W2, Main)			2010	7,000	350	20	350		3,617	18
19	Hallway Wing 2 - Paint, Crown Molding			2010	4,836	322	15	322		3,331	19
20	Facility Signaage - In Building			2010	3,725	310	10	310		3,725	20
21	Dining Room - Paint, Tile Lights/Blinds			2010	3,427	228	15	228		2,322	21
22	Beauty Show - Crown Moldings, Carpet Tile, Cabinet, Light Fixtures, Pai			2011	2,648	177	15	177		1,766	22
23	Garage - Flooring, Electrical Work, Drywall Installation & Paint			2011	6,873	458	15	458		4,468	23
24	Fire Rated Doors & Fire Alarm Control Panel			2011	25,494	2,506	15	2,506		23,012	24
25	Water Heater			2012	1,365	137	10	137		1,206	25
26	Fans for ARCH Units			2013	1,153	115	10	115		845	26
27	Blinds for ARCH Unit			2013	1,820		5			1,820	27
28	Hillside Welcome Sign			2013	1,290	129	10	129		946	28
29	Cabinets for ARCH Unit			2013	2,843	190	15	190		1,390	29
30	Drapes/paint for ARCH Unit			2013	4,880		5			4,880	30
31	Flooring/Sink/Mirror for ARCH Unit			2013	6,011	601	10	601		4,408	31
32	Materials/Labor/Supplies for ARCH Units			2013	32,364	2,158	15	2,158		15,823	32
33	Vanities/Shower/Plumbing			2013	6,004	300	20	300		2,127	33
34	Doors for ARCH Unit			2013	4,053	270	15	270		1,981	34
35	Air Conditioner			2013	2,010	201	10	201		1,524	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 & ID Number Hillside Rehab & Care Center

0050310

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	Valances, Paint, Wall covering, exit lights, new walls, floor		\$	\$		\$	\$		37
38	(cont.) finishes, window for new therapy room	2014	12,814	854	15	854		5,778	38
39	Cabinets for Therapy Room	2014	2,306	154	15	154		999	39
40	Floorign in New Dining Room	2014	1,261	84	15	84		539	40
41	Windows & Wall Coverings for Kitchen Remodel	2014	2,295	153	15	153		956	41
42	New Windows	2014	1,765	177	10	177		1,074	42
43	2 A/C Units	2014	1,650		5			1,650	43
44	New Flooring for Wing 1 & Wing 2	2015	4,020	268	15	268		1,452	44
45	Water Heater	2016	5,800	580	10	580		2,755	45
46	Finishing touches on ARCH Unit & new theray room - trim,								46
47	(cont.) painting, etc.	2016	29,250	1,950	15	1,950		9,750	47
48	Carpet	2018	2,389	478	5	478		1,314	48
49	ARCH Hallway Carpet	2018	2,173	435	5	435		978	49
50	Flooring - Mod Tile Timber Grove	2019	3,894	389	10	389		714	50
51	14 Dry Pendants	2019	5,107	341	15	341		482	51
52	78x84 non Illuminated Monument Sign	2020	8,665	505	10	505		505	52
53	A/C Unit	2020	4,300	143	10	143		143	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Related Party Allocation - Bridgemark Healthcare, LLC								63
64	New Office Build Out	2011	5,055		20	268	268	2,530	64
65	Conference Room Chair Rail & Paint	2012	57		5			57	65
66	AC Unit in Server Room	2018	392		20	20	20	49	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 252,976	\$ 17,682		\$ 17,970	\$ 288	\$ 142,611	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	\$93,062	\$9,321	\$10,935	\$1,614		\$54,559	71
72	Current Year Purchases	17,616	4,582	4,830	248		4,830	72
73	Fully Depreciated Assets	28,605					28,605	73
74								74
75	TOTALS	\$139,283	\$13,903	\$15,765	\$1,862		\$87,994	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	Section N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

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)	\$392,259	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$31,585	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$33,735	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,150	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$230,605	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

☒ YES

☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		79	5/7/18	\$ 339,958			3
4	Additions							4
5	Storage Rental				2,334			5
6	Related Party Allocation				3,976			6
7	TOTAL		79		\$ 346,268			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:\$ 63,832Description: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

Hillside Rehab & Care Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2020

Description		
16A	Nursing Equipment	42,916
16B	Dietary Equipment	360
16C	Copier Lease	6,032
16D	Related Party Allocation - Bridgemark Healthcare	591
16E	Respiratory Equipment Rental	13,933
		<u>63,832</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				255		255	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				104,751		104,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound Care & Oxygen</u>	39, 2					13,713		13,713	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				435,492			435,492	13
14	TOTAL			\$		\$ 435,492	\$ 118,719		\$ 554,211	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	\$ 13,653	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	456,445		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,877		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 472,975	\$	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	240,022		15
16	Equipment, at Historical Cost	137,708		16
17	Accumulated Depreciation (book methods)	(222,576)		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)	\$ 155,154	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 628,129	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 226,947	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,174		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,904		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	6,441		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 335,466	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	284,515		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	131,867		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 416,382	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 751,848	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (123,719)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 628,129	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 152,372	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 152,372	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(276,091)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (276,091)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (123,719)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

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	\$ 4,139,176	1
2	Discounts and Allowances for all Levels	(342,422)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,796,754	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,811	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 167,811	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***	365	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 365	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>CARES Funds</u>	483,508	28
28a	<u>Miscellaneous</u>	1,898	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 485,406	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,450,336	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	720,681	31
32	Health Care	1,589,776	32
33	General Administration	1,228,621	33
	B. Capital Expense		
34	Ownership	511,297	34
	C. Ancillary Expense		
35	Special Cost Centers	553,956	35
36	Provider Participation Fee	122,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,726,427	40
41	Income before Income Taxes (line 30 minus line 40)**	(276,091)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (276,091)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,471,604	44
45	Private Pay - Net Inpatient Revenue	312,953	45
46	Medicare - Net Inpatient Revenue	1,554,350	46
47	Other-(specify) <u>Insurance</u>	335,969	47
48	Other-(specify) <u>Hospice</u>	121,878	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,796,754	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	1,884	2,104	\$ 130,625	\$ 62.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,816	10,800	372,508	34.49	3
4	Licensed Practical Nurses	7,719	7,903	210,811	26.67	4
5	CNAs & Orderlies	26,310	28,100	516,026	18.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,620	2,789	53,944	19.34	10
11	Social Service Workers	1,816	2,074	42,639	20.56	11
12	Dietician					12
13	Food Service Supervisor	2,766	2,990	45,892	15.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,565	7,137	110,142	15.43	15
16	Dishwashers					16
17	Maintenance Workers	1,676	1,960	49,240	25.12	17
18	Housekeepers	7,312	8,030	121,500	15.13	18
19	Laundry					19
20	Administrator	1,911	2,114	115,373	54.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,898	2,199	66,223	30.12	23
24	Clerical	947	999	18,493	18.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	73,240	79,199	\$ 1,853,416 *	\$ 23.40	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		\$ 9,480	1, 3	35
36	Medical Director		8,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,575	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		3,398	10, 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		150	11, 3	44
45	Social Service Consultant		455	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,458		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3,783	125,628	10, 3	52
53	TOTAL (lines 50 - 52)	3,783	\$ 125,628		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Pamela Ingold	Administrator	0	\$ 115,373
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,373
B. Administrative - Other			
Description			Amount
Bridgemark Healthcare, LLC - Management Fees		\$	218,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 218,200
C. Professional Services			
Vendor/Payee	Type		Amount
Personnel Planners	Unemployment Consulting	\$	1,916
Hamlin & Burton Liability Managemen	Legal Fees		10,399
Stein Law Offices	Legal Fees		4,508
C.J. Schlosser & Company, LLC	Accounting Services		4,000
Nationwide Trust	401(k) Admin		978
Pantegra	401(k) Admin		3,100
Paycom Payroll, LLC	Payroll Processing		15,179
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 40,080
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	39,374
Unemployment Compensation Insurance			10,013
FICA Taxes			140,387
Employee Health Insurance			16,264
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401(k) Match			3,922
Employee Benefits			224
Other Employee Insurance			577
Related Party Allocation - Bridgemark			8,783
TOTAL (agree to Schedule V, line 22, col.8)			\$ 219,544
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			4,170
Health Care Worker Background Check (Indicate # of checks performed _____)			1,125
Patient Background Checks			
Dues & Subscriptions			5,693
IHCA Dues			4,125
Miscellaneous Licenses & Fees			5,803
Advertising			29,280
Related Party Allocation - Bridgemark			801
Less: Public Relations Expense	(		)
Non-allowable advertising			(29,280)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 23,707
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			626
Seminar Expense			2,046
Related Party Allocation - Bridgemark			1,324
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	3,996

*** 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?
If YES, give association name and amount.

Yes
IHCA \$4,125

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
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.

\$ 22,175 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 122,096

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ None
No
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes

SEE ACCOUNTANTS' PREPARATION REPORT