

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>0049775</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Helia Healthcare of Benton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1310 Mark Frankln Dr</u> <u>Benton</u> <u>62812</u> Number City Zip Code																									
County: <u>Franklin</u>																									
Telephone Number: <u>(618) 439-3500</u> Fax # <u>(618) 439-3514</u>																									
HFS ID Number: _____																									
Date of Initial License for Current Owners: <u>08/15/2008</u>		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jason Mills</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) <u>See Accountant's Preparation Report</u></td></tr><tr><td>(Print Name and Title) <u>Cindy A. Tefteller</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u></td></tr><tr><td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jason Mills</u>	(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Preparation Report</u>	(Print Name and Title) <u>Cindy A. Tefteller</u> <u>CPA</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u>	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>													
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Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																							
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>83</u>	Skilled (SNF)	<u>83</u>	<u>30,295</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>83</u>	TOTALS	<u>83</u>	<u>30,295</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2,144	7,768	1,743	15	2,800	2,706	503	17,679	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,144	7,768	1,743	15	2,800	2,706	503	17,679	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 58.36%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/15/08

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 83

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	101,320	23,255	168,548	293,123		293,123		293,123			1
2	Food Purchase		148,496		148,496		148,496	(116)	148,380			2
3	Housekeeping	101,834	27,436		129,270		129,270		129,270			3
4	Laundry		27,760	82,694	110,454		110,454	(24,884)	85,570			4
5	Heat and Other Utilities			158,266	158,266		158,266	6,425	164,691			5
6	Maintenance	70,292	15,627	52,946	138,865		138,865	55,993	194,858			6
7	Other (specify):*											7
8	TOTAL General Services	273,446	242,574	462,454	978,474		978,474	37,418	1,015,892			8
	B. Health Care and Programs											
9	Medical Director			4,026	4,026		4,026		4,026			9
10	Nursing and Medical Records	1,608,397	89,835	25,386	1,723,618		1,723,618	512	1,724,130			10
10a	Therapy											10a
11	Activities	48,946	12,436	4,908	66,290		66,290		66,290			11
12	Social Services	48,052		1,823	49,875		49,875		49,875			12
13	CNA Training											13
14	Program Transportation		3,360		3,360		3,360		3,360			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,705,395	105,631	36,143	1,847,169		1,847,169	512	1,847,681			16
	C. General Administration											
17	Administrative	141,812		260,700	402,512		402,512	(251,003)	151,509			17
18	Directors Fees											18
19	Professional Services			31,921	31,921		31,921	8,270	40,191			19
20	Dues, Fees, Subscriptions & Promotions			63,559	63,559		63,559	(16,753)	46,806			20
21	Clerical & General Office Expenses	34,830	11,906	190,261	236,997		236,997	37,830	274,827			21
22	Employee Benefits & Payroll Taxes			264,618	264,618		264,618	35,686	300,304			22
23	Inservice Training & Education											23
24	Travel and Seminar			180	180		180	3,225	3,405			24
25	Other Admin. Staff Transportation			7,047	7,047		7,047	10,561	17,608			25
26	Insurance-Prop.Liab.Malpractice			55,128	55,128		55,128	3,381	58,509			26
27	Other (specify):*											27
28	TOTAL General Administration	176,642	11,906	873,414	1,061,962		1,061,962	(168,803)	893,159			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,155,483	360,111	1,372,011	3,887,605		3,887,605	(130,873)	3,756,732			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			47,114	47,114		47,114	10,709	57,823			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,317	100,317		100,317	(99)	100,218			32
33	Real Estate Taxes			21,323	21,323		21,323	3,990	25,313			33
34	Rent-Facility & Grounds			314,779	314,779		314,779	(297,379)	17,400			34
35	Rent-Equipment & Vehicles			18,047	18,047		18,047	442	18,489			35
36	Other (specify):*											36
37	TOTAL Ownership			501,580	501,580		501,580	(282,337)	219,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,628	303,015	420,643		420,643		420,643			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			250,372	250,372		250,372		250,372			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		117,628	553,387	671,015		671,015		671,015			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,155,483	477,739	2,426,978	5,060,200		5,060,200	(413,210)	4,646,990			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	(7,355)	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	(99)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(116)	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	(51,511)	21		18
19	Entertainment	(4,826)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(140)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,167)	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	(9,179)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,393)		\$	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)	(329,817)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (329,817)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (413,210)		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	Political Action Committee Payments	\$ (2,260)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	To Eliminate Gifts & Flowers	(7,909)	20	3
4	To Eliminate Medical Record Copies	(34)	10	4
5	To Add IDPH Fees	1,024	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,179)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Energy	Energy, IL	Bridgemark Healthcar	St. Ann, MO	Management Co.
		Helia Healthcare of Olney	Olney, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Southbelt Healthcare	Belleville, IL	Bridgemark Employee	St. Ann, MO	Human Resources
		Hillside Rehab and Care Center	Yorkville, IL	Palladian Management	O'Fallon, IL	Nursing/Billing Co.
		Helia Healthcare of Hillsboro	Hillsboro, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Assisted Living
		Helia Healthcare of Florissant	Florissant, MO	Palladian Taylorville A	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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Laundry	\$ 83,950	Helia Healthcare Services	100.00%	\$ 59,066	\$ (24,884)	1
2	V	5	Utilities		Helia Healthcare Services	100.00%	13,780	13,780	2
3	V	6	Maintenance		Helia Healthcare Services	100.00%	55,993	55,993	3
4	V	20	Dues, Fees & Subscriptions		Helia Healthcare Services	100.00%	1,596	1,596	4
5	V	21	Clerical		Helia Healthcare Services	100.00%	3,551	3,551	5
6	V	22	Employee Benefits		Helia Healthcare Services	100.00%	20,453	20,453	6
7	V	24	Travel & Seminar		Helia Healthcare Services	100.00%	1,032	1,032	7
8	V	25	Other Admin Transportation		Helia Healthcare Services	100.00%	7,283	7,283	8
9	V	26	Insurance		Helia Healthcare Services	100.00%	3,117	3,117	9
10	V	30	Depreciation		Helia Healthcare Services	100.00%	5,320	5,320	10
11	V	34	Rent - Facility		Helia Healthcare Services	100.00%	605	605	11
12	V								12
13	V								13
14	Total			\$ 83,950			\$ 171,796	\$ * 87,846	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			\$			\$		15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	546	546	16
17	V	17	Management Fees	260,700	Bridgemark Healthcare, LLC	100.00%	9,697	(251,003)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	8,410	8,410	18
19	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	963	963	19
20	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	90,616	90,616	20
21	V	22	Employee Benefits		Bridgemark Healthcare, LLC	100.00%	15,233	15,233	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,193	2,193	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,278	3,278	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	264	264	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	919	919	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	32	32	26
27	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	4,966	4,966	27
28	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	442	442	28
29	V								29
30	V								30
31	V	30	Depreciation		BM Properties 1 - Benton	100.00%	4,470	4,470	31
32	V	33	Real Estate Taxes	21,323	BM Properties 1 - Benton	100.00%	25,281	3,958	32
33	V	34	Rent	302,950	BM Properties 1 - Benton	100.00%		(302,950)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 584,973			\$ 167,310	\$ * (417,663)	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 related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Helia Healthcare of Jerseyville	Jerseyville, IL				1
2			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				2
3			Helia Healthcare of Effingham	Effingham, IL				3
4			Helia Healthcare of Salem	Salem, IL				4
5			Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO				5
6			Helia Richland Healthcare	Olney, IL				6
7			Helia Healthcare of Newton	Newton, IL				7
8			Palladian Aviston SNF	Aviston, IL				8
9			Palladian Mt. Vernon SNF	Mt. Vernon, IL				9
10			Palladian Taylorville SNF	Taylorville, IL				10
11			Palladian Ucity Manor, LLC	St. Louis, MO				11
12			Palladian Creve Coeur, LLC	St. Louis, MO				12
13								13
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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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	265,303	1.76	3.53	Distribution	\$ 9,697	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	\$ 9,697		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

Ending: 2/31/2025

((314) 754-9176

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Benton # 0049775 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	4	Laundry	Revenue	233,140	2	\$ 164,034	\$ 145,474	83,950	\$ 59,066	1
2	5	Utilities	Revenue	233,140	2	38,270		83,950	13,780	2
3	6	Maintenance	Revenue	233,140	2	155,500	143,530	83,950	55,993	3
4	20	Dues, Fees & Subscriptions	Revenue	233,140	2	4,431		83,950	1,596	4
5	21	Clerical & Office Supplies	Revenue	233,140	2	9,861		83,950	3,551	5
6	22	Payroll Taxes & Emp. Benefits	Revenue	233,140	2	56,801		83,950	20,453	6
7	24	Travel & Seminar	Revenue	233,140	2	2,866		83,950	1,032	7
8	25	Other Admin Transportation	Revenue	233,140	2	20,227		83,950	7,283	8
9	26	Insurance	Revenue	233,140	2	8,657		83,950	3,117	9
10	30	Depreciation	Revenue	233,140	2	14,774		83,950	5,320	10
11	34	Rent - Facility	Revenue	233,140	2	1,680		83,950	605	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 477,101	\$ 289,004		\$ 171,796	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap Funding, IV Trust		X	Line of Credit		10/22/09				Var.		100,317	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 100,317	9
	B. Non-Facility Related*												
10	Interest Income Offset											(99)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (99)	14
15	TOTALS (line 9+line14)						\$					\$ 100,218	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 2024 report.			\$	21,000	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.)			\$	25,281	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,281	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	21,000	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.			\$	25,281	7
Assessed Value from Real Estate Tax Bill:	2024	293,630	8		
Real Estate Tax Bill for Calendar Year:	2020	21,116	9		
	2021	21,156	10		
	2022	22,816	11		
	2023	23,943	12		
	2024	25,281	13		
25,281 Line 7					
32 Related Party Allocations					
25,313 Total Schedule V, Line 33					

FOR BHF USE ONLY			
14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
15	PLUS APPEAL COST FROM LINE 5	\$	15
16	LESS REFUND FROM LINE 6	\$	16
17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Benton COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0049775

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 431-0511 FAX #: (618) 754-9176

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-07-455-802	Nursing Home	\$ 25,280.96	\$ 25,280.96
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 25,280.96	\$ 25,280.96

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,067 B. General Construction Type: Exterior Brick Masonry Frame Metal Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (a) Own the Equipment (X) (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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.
N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Related Party Allocation - Helia Healthcare			\$ 1,804	1
2					2
3	TOTALS			\$ 1,804	3

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	Helia Healthcare Allocation		2006		\$ 48,085	\$	25	\$ 2,404	\$ 2,404	\$ 27,761	4
5	83		2008		134,098		30	4,470	4,470	77,851	5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse's Station			2009	1,221		15			1,221	9
10	Exterior Sign			2009	5,265		10			5,265	10
11	Wallcoverings for Hallways & Entranceway, Doors, Shower Remodel			2009	11,252		15			11,252	11
12	Nurse's Station Remodel/Wiring			2009	2,556		15			2,556	12
13	New Pipes, Install Eye Wash			2010	2,215	89	25	89		1,381	13
14	A/C, Fans, Dehumidifer			2010	1,609		10			1,609	14
15	Outside Single Door & Frame			2010	4,168	208	15	208		4,168	15
16	Shower Room - Tile, Shower Heads Electrical Work, Fixtures, Paint,			2011	17,553	1,170	15	1,170		17,065	16
17	Dinette/Common Area Remodel - Doors, Windows, Countertops										17
18	(Cont..) Cabinetry, Flooring, Electrical, Plywood, Paint										18
19	Back-up Generator			2011	12,864	643	20	643		9,219	19
20	Sprinkler System			2012	97,800	3,912	25	3,912		54,768	20
21	Fire Doors			2012	9,943	663	15	663		9,169	21
22	Oxygen Shed			2012	1,941		10			1,941	22
23	A/C Rquipment North Hallway			2014	1,896		10			1,896	23
24	Painting 1 Room, 1/2 North Hall			2014	250		5			250	24
25	Therapy Reomodel - Flooring, Painting, & Lighting			2015	4,045	270	15	270		2,876	25
26	Vinyl Sliding Door & Installation			2015	5,325	355	15	355		3,698	26
27	Flooring in North Hall Rooms & Hallways			2015	7,282	485	15	485		5,017	27
28	Lighting, Drywall, Paint, and Flooring in Back Hallway			2017	4,690	313	15	313		2,658	28
29	New Countertop and Paint for Nurse Station in South Hall			2017	2,922	195	15	195		1,607	29
30	Therapy Room Lights, Flooring, Paint, Door Handles, and New Cabinets			2017	18,640	1,243	15	1,243		10,459	30
31	Portable Building - Cook Portable Warehouse			2020	5,342	356	15	356		1,899	31
32	Water Heater			2022	35,895	3,589	10	3,589		13,461	32
33	LED Lighting Upgrade			2023	4,596	460	10	460		1,264	33
34	2 New Flush Valves			2024	4,160	416	10	416		728	34
35	Replace LOOP for A/C			2024	4,875	488	10	488		772	35
36	Repair EPDM Roof System - North			2024	11,716	1,172	10	1,172		1,660	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

Facility Name & ID Number Helia Healthcare of Benton

0049775

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	Roof	2025	\$ 1,139,597	\$ 18,993	15	\$ 18,993	\$	\$ 18,993	37
38	Roof Drains	2025	6,684	222	10	222		223	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46	Related Party Allocation - Bridgemark Healthcare, LLC								46
47	New Office - Logo Signs - NW Plaza	2021	139		10	14	14	58	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55	Related Party Allocation - Helia Healthcare								55
56	Water & Sewer Pipe Installation	2006	684		20	34	34	664	56
57	Plumbing & Heating Installation	2006	819		20	41	41	795	57
58	400 Gal. Water Storage Tank	2016	5,567		10	557	557	5,243	58
59	A/C Compressor at Martin's Catering Building	2018	900		15	60	60	450	59
60	Rooftop A/C Unit - Laundry Building	2021	2,385		10	238	238	1,153	60
61	Water Heater	2022	875		10	88	88	321	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,619,854	\$ 35,242		\$ 43,148	\$ 7,906	\$ 301,371	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	\$138,657	\$10,559	\$12,245	\$1,686		\$97,614	71
72	Current Year Purchases	29,587	1,313	1,971	658		1,971	72
73	Fully Depreciated Assets	106,466					106,466	73
74								74
75	TOTALS	\$274,710	\$11,872	\$14,216	\$2,344		\$206,051	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2011	\$28,821	\$	\$	\$	4	\$28,821	76
77	Facility	2006 Dodge Grand Caravan	2019	3,518				4	3,518	77
78										78
79	Related Party Allocation - Helia Healthcare		2006	5,641		459	459		5,641	79
80	TOTALS			\$37,980	\$	\$459	\$459		\$37,980	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)	\$1,934,348	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$47,114	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$57,823	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$10,709	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$545,402	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Section N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☐ YES☒ NO

		1 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:				\$			3
4	Additions							4
5	Storage				11,829			5
6	Related Party Allocation				5,571			6
7	TOTAL				\$ 17,400			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the leaseN/A.
9. Option to Buy:☐ YES☒ X NO Terms: *

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

15. Is Movable equipment rental included in building rental?☐ YES☒ X NO
16. Rental Amount for movable equipment: \$ 18,489 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Helia Healthcare of Benton
Attachment to Schedule XII B
Equipment Rentals
12/31/2025

Description		
16A	Nursing Equipment	16,742
16B	Copier Lease	883
16C	Dietary Equipment	10
16D	Related Party Allocation - Bridgemark Healthcare	442
16E	Respiratory Equipment	412
		<u>18,489</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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				97,016		97,016	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen, Wound, Enter</u>	39, 2					20,612		20,612	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				303,015			303,015	13
14	TOTAL			\$		\$ 303,015	\$ 117,628		\$ 420,643	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	\$ (18,251)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,900)	382,548		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	603		6
7	Other Prepaid Expenses	345		7
8	Accounts Receivable (owners or related parties)	6,520,734		8
9	Other(specify): Deposits	2,163		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,888,142	\$	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	1,426,302		15
16	Equipment, at Historical Cost	242,688		16
17	Accumulated Depreciation (book methods)	(367,167)		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)	\$ 1,301,823	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,189,965	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 445,806	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	234,540		29
30	Accrued Salaries Payable	56,644		30
31	Accrued Taxes Payable (excluding real estate taxes)			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 Expenses	2,878,121		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,615,111	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	123,729		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 123,729	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,738,840	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,451,125	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,189,965	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,686,587	1
2	Restatements (describe):		2
3	Prior Year Adj - Due to other funds	4,204	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,690,791	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	760,334	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)	\$ 760,334	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)	\$ 4,451,125	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Helia Healthcare of Benton

0049775

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 5,787,881	1
2	Discounts and Allowances for all Levels	(802,580)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,985,301	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	103,079	6
7	Oxygen	7,903	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 110,982	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***	99	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 99	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	655,580	27
28	Quarterly Incentive Payments	66,952	28
28a	Miscellaneous	1,620	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 724,152	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,820,534	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	978,474	31
32	Health Care	1,847,169	32
33	General Administration	1,061,962	33
	B. Capital Expense		
34	Ownership	501,580	34
	C. Ancillary Expense		
35	Special Cost Centers	420,643	35
36	Provider Participation Fee	250,372	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,060,200	40
41	Income before Income Taxes (line 30 minus line 40)**	760,334	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 760,334	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 461,759.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,673,016.00	45
46	MMAI-Medicaid is the Primary Payer	375,395.00	46
47	MMAI-Medicare is the Primary Payer	9,501.00	47
48	Private Pay	536,031.00	48
49	Medicare Part A	1,713,922.00	49
50	Other-(specify) Managed Care	215,677.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,985,301	56

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,161	2,161	\$ 93,808	\$ 43.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,185	7,311	314,814	43.06	3
4	Licensed Practical Nurses	11,109	11,215	380,491	33.93	4
5	CNAs & Orderlies	35,943	36,303	819,284	22.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,624	2,641	48,946	18.53	10
11	Social Service Workers	1,284	1,304	48,052	36.85	11
12	Dietician					12
13	Food Service Supervisor	766	778	17,594	22.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,407	5,426	83,726	15.43	15
16	Dishwashers					16
17	Maintenance Workers	2,476	2,476	70,292	28.39	17
18	Housekeepers	6,204	6,204	101,834	16.41	18
19	Laundry					19
20	Administrator	2,060	2,104	99,956	47.51	20
21	Assistant Administrator	1,245	1,271	41,856	32.93	21
22	Other Administrative					22
23	Office Manager	1,035	1,057	34,830	32.95	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	79,499	80,251	\$ 2,155,483 *	\$ 26.86	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		\$ 168,548	1, 3	35
36	Medical Director		4,026	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,109	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		1,583	11, 3	44
45	Social Service Consultant		1,823	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 181,089		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Helia Healthcare of Benton

0049775Report Period Beginning:01/01/2025Ending:12/31/2025

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Loretta Ellis

Administrator

0

\$ 55,477

Jackie Johnson

Administrator

0

44,479

Ashley Davis

Asst Admin

0

41,856

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

(List each licensed administrator separately.)

\$ 141,812

B. Administrative - Other

Description

Amount

Bridgemark Healthcare LLC - Management Fees

\$ 260,700

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

(Attach a copy of any management service agreement)

\$ 260,700

C. Professional Services

Vendor/Payee

Type

Amount

C.J. Schlosser & Company, LLC

Accounting Services

\$ 3,825

Mathis, Marifian, & Richter LTD

Legal Fees - Collections

140

Saric Consulting

Medicaid Consulting

10,125

Personnel Planners

Unemployment Consulting

1,733

Paylocity

Payroll

16,098

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

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

\$ 31,921

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 46,766

Unemployment Compensation Insurance

11,944

FICA Taxes

163,737

Employee Health Insurance

32,150

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k Match

6,109

Employee Benefits

3,912

Related Party Allocations - Bridgemark

15,233

Related Party Allocations - Helia Healthcare

20,453

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

\$ 300,304

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

20,536

Health Care Worker Background Check

4,498

(Indicate # of checks performed)

Patient Background Checks

Association Dues (total from pg 22, #4)

7,039

Dues & Subscriptions

8,483

Miscellaneous Licenses & Fees

3,961

Advertising

10,167

Related Party Allocations

2,559

Less: Public Relations Expense

()

PAC and Lobbying payments

(2,260)

All non-allowable advertising

(10,167)

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

\$ 46,806

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Online Training

180

Related Party Allocations - Bridgemark

2,193

Related Party Allocations - Helia Healthcare

1,032

Entertainment Expense

()

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

TOTAL

\$ 3,405

* 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) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>4,779</u> |
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | |
| | |
| | <u>4,779</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | |
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>2,260</u> |
| | |
| | |
| | <u>2,260</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>4,779</u> |
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>2,260</u> |
| | |
| | |
| | <u>7,039</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 20,567 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 250,372
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) 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? None Indicate the amount. \$ N/A
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A No
- (13) Has an audit been performed by an independent certified public accounting firm?
Firm Name: N/A No
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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.