

		FOR BHF USE					

LL1

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>0046672</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Helia Healthcare of Energy</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>210 E College Bx 519</u> <u>Energy</u> <u>62933</u>			
Number City Zip Code			
County: <u>Williamson</u>			
Telephone Number: <u>(618) 942-7014</u> Fax # <u>(618) 942-7196</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>02/01/04</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>	
		Paid Preparer	
		(Signed) <u>See Accountant's Preparation Report</u> (Date) _____	
		(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>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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>4/20/2022</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	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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	5,366	8,772	2,645	106	3,502	5,374	1,104	26,869	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,366	8,772	2,645	106	3,502	5,374	1,104	26,869	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 75.12%

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 12/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/01/2003 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 94

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25
* All facilities other than governmental must report on the accrual basis.

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	249,363	21,991	10,160	281,514		281,514		281,514			1
2	Food Purchase		180,281		180,281		180,281	(116)	180,165			2
3	Housekeeping	194,951	33,242	3,140	231,333		231,333		231,333			3
4	Laundry		9,153	149,190	158,343		158,343	(44,222)	114,121			4
5	Heat and Other Utilities			146,964	146,964		146,964	14,335	161,299			5
6	Maintenance	64,609	17,659	63,703	145,971		145,971	99,507	245,478			6
7	Other (specify):*											7
8	TOTAL General Services	508,923	262,326	373,157	1,144,406		1,144,406	69,504	1,213,910			8
	B. Health Care and Programs											
9	Medical Director			3,432	3,432		3,432		3,432			9
10	Nursing and Medical Records	2,535,287	87,315	15,456	2,638,058		2,638,058	794	2,638,852			10
10a	Therapy											10a
11	Activities	41,672	10,184	6,664	58,520		58,520		58,520			11
12	Social Services	78,819		2,813	81,632		81,632		81,632			12
13	CNA Training											13
14	Program Transportation			15,210	15,210		15,210		15,210			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,655,778	97,499	43,575	2,796,852		2,796,852	794	2,797,646			16
	C. General Administration											
17	Administrative	174,354		425,600	599,954		599,954	(410,862)	189,092			17
18	Directors Fees											18
19	Professional Services			39,316	39,316		39,316	12,022	51,338			19
20	Dues, Fees, Subscriptions & Promotions			167,611	167,611	(455)	167,156	(124,420)	42,736			20
21	Clerical & General Office Expenses	59,775	34,537	136,291	230,603		230,603	136,759	367,362			21
22	Employee Benefits & Payroll Taxes			427,241	427,241		427,241	59,499	486,740			22
23	Inservice Training & Education											23
24	Travel and Seminar			504	504	455	959	5,167	6,126			24
25	Other Admin. Staff Transportation			8,151	8,151		8,151	17,926	26,077			25
26	Insurance-Prop.Liab.Malpractice			199,209	199,209		199,209	5,941	205,150			26
27	Other (specify):*											27
28	TOTAL General Administration	234,129	34,537	1,403,923	1,672,589		1,672,589	(297,968)	1,374,621			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,398,830	394,362	1,820,655	5,613,847		5,613,847	(227,670)	5,386,177			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			110,518	110,518		110,518	10,851	121,369			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,572	49,572		49,572	(274)	49,298			32
33	Real Estate Taxes			72,000	72,000		72,000	49	72,049			33
34	Rent-Facility & Grounds			620,832	620,832		620,832	8,622	629,454			34
35	Rent-Equipment & Vehicles			46,427	46,427		46,427	672	47,099			35
36	Other (specify):*											36
37	TOTAL Ownership			899,349	899,349		899,349	19,920	919,269			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		274,291	512,252	786,543		786,543		786,543			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			379,302	379,302		379,302		379,302			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		274,291	891,554	1,165,845		1,165,845		1,165,845			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,398,830	668,653	3,611,558	7,679,041		7,679,041	(207,750)	7,471,291			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	(10,155)	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	(274)	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	(295)	20		17
18	Fines and Penalties	(113,328)	20		18
19	Entertainment	(6,372)	21		19
20	Contributions	(900)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(760)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,378)	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	(2,753)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (147,331)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(60,419)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (60,419)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (207,750)		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	\$ (2,663)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	To Eliminate Gifts & Flowers	(525)	20	3
4	To Add IDPH Fees	471	20	4
5	To Offset Medical Records Income	(36)	10	5
6				6
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48				48
49	Total	(2,753)		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 Benton	Benton, IL	Bridgemark Healthcar	St. Ann, MO	Management Co.
		Hillside Rehab & Care Center	Yorkville, IL	Helia Healthcare Servi	Benton, IL	Laundry Maint.
		Helia Healthcare of Olney	Olney, IL	Bridgemark Employee	St. Ann, MO	Human Resources
		Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO	Palladian Management	O'Fallon, IL	Nursing/Billing Co.
		Helia Southbelt of Healthcare	Belleville, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Assisted Living
		Helia Healthcare of Jerseyville	Jerseyville, IL	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	10	Nursing & Medical Records	\$	Bridgemark Healthcare, LLC	100.00%	\$ 830	\$ 830	1
2	V	17	Management Fees	425,600	Bridgemark Healthcare, LLC	100.00%	14,738	(410,862)	2
3	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	12,782	12,782	3
4	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,463	1,463	4
5	V	21	Clerical & Office Supplies		Bridgemark Healthcare, LLC	100.00%	137,721	137,721	5
6	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	23,151	23,151	6
7	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,333	3,333	7
8	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,982	4,982	8
9	V	26	Insruance		Bridgemark Healthcare, LLC	100.00%	401	401	9
10	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,397	1,397	10
11	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	49	49	11
12	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,547	7,547	12
13	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	672	672	13
14	Total			\$ 425,600			\$ 209,066	\$ * (216,534)	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								16
17	V								17
18	V								18
19	V	4	Laundry	149,190	Helia Healthcare Services	100.00%	104,968	(44,222)	19
20	V	5	Utilities		Helia Healthcare Services	100.00%	24,490	24,490	20
21	V	6	Maintenance		Helia Healthcare Services	100.00%	99,507	99,507	21
22	V	20	Fees, Subs, Promos		Helia Healthcare Services	100.00%	2,835	2,835	22
23	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	6,310	6,310	23
24	V	22	Payroll Taxes & Emp. Benefits		Helia Healthcare Services	100.00%	36,348	36,348	24
25	V	24	Travel & Seminar		Helia Healthcare Services	100.00%	1,834	1,834	25
26	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	12,944	12,944	26
27	V	26	Insurance		Helia Healthcare Services	100.00%	5,540	5,540	27
28	V	30	Depreciation		Helia Healthcare Services	100.00%	9,454	9,454	28
29	V	34	Rent		Helia Healthcare Services	100.00%	1,075	1,075	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			\$ 149,190			\$ 305,305	\$ * 156,115	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Ownership Listing-1

Helia Healthcare of Energy

ID#0046672

Report Period Beginning:01/01/2025

Ending:12/31/2025

N/A

Bridgemark Healthcare

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Place of Residence

Ownership Percentage

Ownership Percentage

Ownership Percentage

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1StephenPMillerChicagoIL100.00000

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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 Hillsboro	Hillsboro, IL				1
2			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Effingham	Effingham, IL				4
5			Helia Healthcare of Salem	Salem, IL				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 Creve Coeur, LLC	St. Louis, MO				11
12			Palladian Ucity Manor, LLC	St. Louis, MO				12
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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	260,262	2.68	5.36	Distribution	\$ 14,738	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	\$ 14,738		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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 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	10	Nursing & Medical Supplies	Resident Days	501,356	17	\$ 15,484	\$	26,869	\$ 830	1
2	17	Owner's Compensation	Resident Days	501,356	17	275,000		26,869	14,738	2
3	19	Professional Fees	Resident Days	501,356	17	238,508		26,869	12,782	3
4	20	Dues & Subscriptions	Resident Days	501,356	17	27,301		26,869	1,463	4
5	21	Salaries - Other	Resident Days	501,356	17	2,420,036	2,420,036	26,869	129,696	5
6	21	Clerical & Office Supplies	Resident Days	501,356	17	149,739		26,869	8,025	6
7	22	Emp. Benefits & Payroll Taxes	Resident Days	501,356	17	431,982		26,869	23,151	7
8	24	Seminars	Resident Days	501,356	17	62,195		26,869	3,333	8
9	25	Admin Staff Travel	Resident Days	501,356	17	92,967		26,869	4,982	9
10	26	Insurance	Resident Days	501,356	17	7,490		26,869	401	10
11	30	Depreciation	Resident Days	501,356	17	26,061		26,869	1,397	11
12	33	Real Estate Taxes	Resident Days	501,356	17	905		26,869	49	12
13	34	Building Rent	Resident Days	501,356	17	111,678		26,869	5,985	13
14	34	Storage Unit Rent	Resident Days	501,356	17	29,142		26,869	1,562	14
15	35	Equipment Rental	Resident Days	501,356	17	12,543		26,869	672	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,901,031	\$ 2,420,036		\$ 209,066	25

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2025

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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 I, LLC		X	Line of Credit		10/22/09					Var.	49,572	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 49,572	9
	B. Non-Facility Related*												
10	Interest Income Offset											(274)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (274)	14
15	TOTALS (line 9+line14)							\$				\$ 49,298	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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)				\$	72,0002
3. Under or (over) accrual (line 2 minus line 1).				\$	72,0003
4. Real Estate Tax accrual used for 2025 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.				\$	6
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.				\$	72,0007
Assessed Value from Real Estate Tax Bill:	2024	850,553	8		
Real Estate Tax Bill for Calendar Year:	2020	75,840	9		
	2021	51,802	10		
	2022	55,092	11		
	2023	51,166	12		
	2024	59,086	13		
72,000 Line 7, Real Estate Tax Portion of Lease Payment					
49 Bridgemark Healthcare Allocation					
72,049 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.

SEE ACCOUNTANTS' PREPARATION REPORT

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

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 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. 06-06-227-019	Long Term Care	\$ 59,086.22	\$ 59,086.22
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 59,086.22	\$ 59,086.22

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: 39,850 B. General Construction Type: Exterior Brick Veneer Frame Masonry Brick Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(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).
Home Adjacent to Facility - 206 East College (no assets or expenses are included for the building on the cost report).

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 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			\$ 3,206	1
2					2
3	TOTALS			\$ 3,206	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	Helia Healthcare Allocation		2006		\$ 85,451	\$	25	\$ 4,273	\$ 4,273	\$ 49,336
5										
6										
7										
8										
	Improvement Type**									
9	Prior Owner Costs:									
10	"C" Wing Signs		2004		1,752					
11	Handrail Molding		2004		1,000					
12	Wallpaper		2004		1,740					
13	Wallpaper		2004		1,062					
14	Room Signs		2004		1,357					
15	Paint Border		2004		2,253					
16	Door Handles & Knobs		2004		729					
17	Border for B Wing		2004		582					
18	Wallpaper for C Wing		2004		1,107					
19	Handrails, Brackets		2004		1,093					
20	Wire Smoke Detectors		2004		572					
21	Door Knobs, B&C Wings		2004		766					
22	2 Wall A/C Unit		2005		1,035					
23	Rooftop HVAC Unit		2006		13,757					
24	5 Wall A/C Units		2006		3,242					
25	Smoke Detectors		2006		749					
26	Fence		2006		573					
27	Glass Door & Installs		2007		1,210					
28	Rooftop HVAC Unit		2007		17,623					
29	80 Gallon Water Heater		2007		2,829					
30	Trailer for Resident Smokers		2008		1,295					
31	Doors		2008		8,553					
32	Wall Air Conditioner		2008		3,040					
33	3 Wall A/C Units		2009		3,686					
34	New Doors, Flooring, Wallcovering, for Entrance and Wing		2009		56,401					
35	Roof Repair		2009		2,000					
36	Call Cords		2009		1,255					

*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 Energy

0046672

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	Exterior Brickwork Improvements	2010	\$ 7,712	\$		\$	\$	\$	37
38	New Asphalt Parking Lot	2010	22,840						38
39	Heat/Water Pump System	2010	9,800						39
40	A/C Compressor Replacement	2010	1,999						40
41	Fire Protect System: Arch Wing	2010	7,971						41
42	15 Heat/Cool Wall Units	2010	7,753						42
43	10 Heat/Cool Wall Units	2010	5,530						43
44	Phone System	2010	17,144						44
45	S Hall (22rms)- New Doors, Windows, Bathrooms, Paint, Drywall	2011	56,140						45
46	W Hall (rms)- New Doors, Windows, Bathrooms, Paint, Drywall	2011	22,456						46
47	Nursing Station Improve- New Cabinets, Counter, Wiring, Floor	2011	22,456						47
48	Dining Room- Flooring, Drywall, Light Fixtures, Paint	2011	33,684						48
49	Resident Lounge Area- Electrical, Light Fixtures, Drywall, Paint	2011	22,456						49
50	Resident Kitchen Area- Sinks, Flooring, Wiring, Paint, Drywall	2011	11,228						50
51	Therapy Room- Flooring, Drywall, Paint, Lighting, Window, Lab	2011	22,456						51
52	2 Shower Rooms- Tile Shower Heads, Fixtures, Paint, Plumbing	2011	33,684						52
53	Arch (rehab) Unit- Labor, Doors, Windows, Drywall, Paint, Floor	2011							53
54	(cont..) Fire Alarms, Plumbing, Architect Fees	2011	70,667						54
55	Exterior Brickwork Improvements	2011	3,600						55
56	21 Wall A/C Units	2012	8,691						56
57	New Central Air Unit on A Wing	2012	2,700						57
58	Flooring	2012	1,780						58
59	Door Monitors and Keypads	2012	1,707						59
60	Heat/Cool Wall Units	2012	4,580						60
61	Bed Additions in ARCH Unit	2013	34,951						61
62	Heat/Cool Units	2013	3,919						62
63									63
64	Current Owner Additions:								64
65	4 A/C Units	2014	2,586		5			2,586	65
66	Tile, Paint, Vanities, Toliets- A Wing	2014	3,971		10			3,971	66
67	A Wing Nurses Station	2014	1,450		10			1,450	67
68	Windows, Laminate Tops, Paint, Tile B Wing	2014	15,282	1,019	15	1,019		11,207	68
69	Kitchen, Wiring Install	2014	990		10			990	69
70	TOTAL (lines 4 thru 69)		\$ 678,895	\$ 1,019		\$ 5,292	\$ 4,273	\$ 69,540	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy

0046672

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	
1	Totals from Page 12A, Carried Forward		\$ 678,895	\$ 1,019		\$ 5,292	\$ 4,273	\$ 69,540	1
2	CTS TECH Phone Line Upgrade/Cabling Install	2014	5,113		10			5,113	2
3	Security 1- Alarm System Install	2015	1,950		10			1,950	3
4	Windows	2015	925		10			925	4
5	A Wing - Remodel Floor, Tile, Paint	2015	5,594	373	15	373		4,071	5
6	Kitchen Flooring & Laminate Countertops	2016	5,272	351	15	351		3,632	6
7	Vinyl Tile A-Wing	2016	9,121	912	10	912		8,969	7
8	Fire Alarm Replacement & 12 YR Suppression	2016	5,293	529	10	529		5,161	8
9	ARCH Remodel- Labor, Doors, Windows, Drywall, Paint								9
10	(cont..) Flooring, Fire Alarms, Plumbing, Architect Fees	2016	99,999	5,000	20	5,000		50,000	10
11	Front Door	2017	3,217	322	10	322		2,815	11
12	Therapy Room/ARCH Remodel- Paint Trim, Door	2017	13,970	519	20	519		4,525	12
13	300 KW CAT Generator Install & Electric	2018	9,143		5			9,143	13
14	New Door Keypads, Power Supplies, Relay & System	2019	4,275	428	10	428		2,886	14
15	Roof Replacement	2019	58,387	5,839	10	5,839		40,871	15
16	Generator Installation, Engineer Fees	2019	7,700		5			7,700	16
17	Hot Water Heater and Garbage Disposal	2019	3,250		5			3,250	17
18	Driveway	2019	3,000		5			3,000	18
19	New D/F High Density Foam Sign 5x7 w/LED	2019	7,932	793	10	793		4,297	19
20	Refurbish Sign 2 New Faces, Repaint, Texture	2020	8,683	868	10	868		4,703	20
21	Cabling, Rewiring of TV System Entire Facility	2021	6,340	634	10	634		2,906	21
22	Relocate 3 Phase Electric for Generator	2021	11,098	1,110	10	1,110		4,624	22
23	AO Smith 3 Phase DRE Series - Replace Water Heater	2021	8,700	870	10	870		3,552	23
24	Tuckpointing	2021	5,575	1,115	5	1,115		4,460	24
25	B-Wing Construction	2022	1,700,247	68,010	25	68,010		204,030	25
26	Hot Water Tank	2024	4,638	464	10	464		773	26
27	Water Heater	2024	3,150	315	10	315		315	27
28	New roof, gutters, downspouts - A Wing	2025	85,188	4,259	15	4,259		4,259	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,756,655	\$ 93,730		\$ 98,003	\$ 4,273	\$ 457,470	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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	\$199,851	\$16,346	\$19,143	\$2,797		\$106,425	71
72	Current Year Purchases	15,787	442	1,577	1,135		1,577	72
73	Fully Depreciated Assets	61,745					61,745	73
74								74
75	TOTALS	\$277,383	\$16,788	\$20,720	\$3,932		\$169,747	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	Signature Auto Group - Van	2014	\$9,938	\$	\$	\$	4	\$9,938	76
77										77
78	Related Party Allocation - Helia Healthcare		Var.	10,026		816	816		10,026	78
79										79
80	TOTALS			\$19,964	\$	\$816	\$816		\$19,964	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,077,381	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$110,518	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$121,369	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$10,851	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$662,601	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:OMG Energy Property, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		98	5/7/18	\$ 615,600			3
4	Additions							4
5	Storage Rental				5,232			5
6	Related Party Allocation				8,622			6
7	TOTAL		98		\$ 629,454			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☒ 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: \$ 47,099 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 Energy
Attachment to Schedule XII B
Equipment Rentals
12/31/2025

Description		
16A	Nursing Equipment	3,605
16B	Copier and Computer Leases	10,365
16C	Related Party Allocation - Bridgemark Healthcare	672
16D	Respiratory Equipment	30,310
16E	Dietary Equipment	2,147
		<u>47,099</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
		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)	\$			

- (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.

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	

- (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				234,564		234,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39, 2					39,727		39,727	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				512,252			512,252	13
14	TOTAL			\$		\$ 512,252	\$ 274,291		\$ 786,543	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	\$ (68,097)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (38,300))	835,504		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,702		7
8	Accounts Receivable (owners or related parties)	185,993		8
9	Other(specify): Deposits	4,351		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 967,453	\$	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	2,098,529		15
16	Equipment, at Historical Cost	246,496		16
17	Accumulated Depreciation (book methods)	(553,825)		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): Right of Use Asset	5,560,374		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,351,574	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,319,027	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 926,979	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	486,620		29
30	Accrued Salaries Payable	152,111		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 Provider Tax	34,726		36
37	Accrued CMPs	14,370		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,614,806	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	180,106		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Lease Liability	5,608,369		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,788,475	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,403,281	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 915,746	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,319,027	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 226,153	1
2	Restatements (describe):		2
3	Prior Year Adjustments	18,114	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 244,267	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	671,479	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)	\$ 671,479	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)	\$ 915,746	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

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	\$ 9,913,840	1
2	Discounts and Allowances for all Levels	(1,676,006)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,237,834	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	58,737	6
7	Oxygen	24,607	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 83,344	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***	274	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 274	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Quarterly Incentive Payment	28,966	28
28a	Miscellaneous	102	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,068	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,350,520	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,144,406	31
32	Health Care	2,796,852	32
33	General Administration	1,672,589	33
	B. Capital Expense		
34	Ownership	899,349	34
	C. Ancillary Expense		
35	Special Cost Centers	786,543	35
36	Provider Participation Fee	379,302	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,679,041	40
41	Income before Income Taxes (line 30 minus line 40)**	671,479	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 671,479	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,136,169.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,857,338.00	45
46	MMAI-Medicaid is the Primary Payer	560,039.00	46
47	MMAI-Medicare is the Primary Payer	57,191.00	47
48	Private Pay	549,931.00	48
49	Medicare Part A	3,481,516.00	49
50	Other-(specify) Managed Care	595,650.00	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)	\$ 8,237,834	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	2,095	2,132	\$ 104,908	\$ 49.21	1
2	Assistant Director of Nursing	2,012	2,044	79,495	38.89	2
3	Registered Nurses	12,378	12,529	556,430	44.41	3
4	Licensed Practical Nurses	13,682	13,815	531,829	38.50	4
5	CNAs & Orderlies	52,021	52,611	1,262,625	24.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,031	2,059	41,672	20.24	10
11	Social Service Workers	2,125	2,148	78,819	36.69	11
12	Dietician					12
13	Food Service Supervisor	5,079	5,173	130,933	25.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,342	7,381	118,430	16.05	15
16	Dishwashers					16
17	Maintenance Workers	2,231	2,283	64,609	28.30	17
18	Housekeepers	12,176	12,356	194,951	15.78	18
19	Laundry					19
20	Administrator	2,150	2,192	105,859	48.29	20
21	Assistant Administrator	2,114	2,157	68,495	31.75	21
22	Other Administrative					22
23	Office Manager	2,275	2,314	59,775	25.83	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)	119,711	121,194	\$ 3,398,830 *	\$ 28.04	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		\$ 10,160	1, 3	35
36	Medical Director		3,432	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,744	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,813	11, 3	44
45	Social Service Consultant		2,813	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,962		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Andrew Tholen	Administrator	0	\$ 105,859
Judy Minor	Asst Administrator	0	68,495
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 174,354
B. Administrative - Other			
Description			Amount
Bridgemark Healthcare, LLC - Management Fees		\$	425,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 425,600
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company, LLC	Accounting Services	\$	3,825
Polsinelli PC	Legal Fees		513
Saric Consulting	Claims Management		7,056
Mathis Marifian & Richter LTD	Legal Fees - Collections		760
Personnel Planners	Unemployment Consulting		1,733
Paycom Payroll	Payroll Processing		25,429
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 39,316
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	81,620
Unemployment Compensation Insurance			22,021
FICA Taxes			257,368
Employee Health Insurance			57,709
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k Match			6,647
Employee Benefits			1,876
Related Party Allocations - Bridgemark			23,151
Related Party Allocations - Helia Healthcare			36,348
TOTAL (agree to Schedule V, line 22, col.8)			\$ 486,740
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 (Indicate # of checks performed _____)			175
Patient Background Checks			
Association Dues (total from pg 22, #4)			8,305
Dues & Subscriptions			7,747
Miscellaneous Licenses & Fees			2,348
Advertising			12,378
Related Party Allocations			4,298
Less: Public Relations Expense (_____)			
PAC and Lobbying payments			(2,663)
All non-allowable advertising			(12,378)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 42,736
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			959
Related Party Allocation			5,167
Entertainment Expense (_____)			
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 6,126

*** 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
IL HEALTHCARE ASSOCIATION (IHCA)	
HEALTH CARE COUNCIL OF IL (HCCI)	5,642
	5,642 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.

IL HEALTHCARE ASSOCIATION (IHCA)	73
HEALTH CARE COUNCIL OF IL (HCCI)	2,590
	2,663 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	73
HEALTH CARE COUNCIL OF IL (HCCI)	8,232
	8,305 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$28,941 Line10

(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. \$379,302 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? No 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? N/A

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

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

g. Does the facility transport residents to and from day training? No Indicate the amount of income earned from providing such transportation during this reporting period. \$N/A

(13) Has an audit been performed by an independent certified public accounting firm? No Firm Name: N/A

(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.