

		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: 0048587

Facility Name: Helia Southbelt Healthcare

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

County: Saint Clair

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

HFS ID Number:

Date of Initial License for Current Owners: 10/02/2008

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) (Date)

(Type or Print Name) Jason Mills

(Title) Chief Financial Officer

Paid
Preparer

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

(Print Name and Title) Cindy A. Tefteller
CPA

(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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	156	Skilled (SNF)	156	56,940	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	156	TOTALS	156	56,940	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	5,842	21,481	1,327	166	2,310	2,546	835	34,507	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,842	21,481	1,327	166	2,310	2,546	835	34,507	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 60.60%

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 10/02/2008

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/02/2008 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 156

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

Facility Name & ID Number		Helia Southbelt Healthcare				# 0048587		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	310,690	31,763	20,186	362,639		362,639		362,639			1	
2	Food Purchase		224,632		224,632		224,632	(74)	224,558			2	
3	Housekeeping	305,098	24,693	2,513	332,304		332,304		332,304			3	
4	Laundry	37,223	12,725		49,948		49,948		49,948			4	
5	Heat and Other Utilities			192,042	192,042		192,042	(12,155)	179,887			5	
6	Maintenance	107,791	12,025	91,229	211,045		211,045		211,045			6	
7	Other (specify):*											7	
8	TOTAL General Services	760,802	305,838	305,970	1,372,610		1,372,610	(12,229)	1,360,381			8	
	B. Health Care and Programs												
9	Medical Director			22,000	22,000		22,000		22,000			9	
10	Nursing and Medical Records	4,635,233	250,472	11,258	4,896,963		4,896,963	600	4,897,563			10	
10a	Therapy		87		87		87		87			10a	
11	Activities	104,663	3,931	7,169	115,763		115,763		115,763			11	
12	Social Services	41,486		2,754	44,240		44,240		44,240			12	
13	CNA Training											13	
14	Program Transportation			12,271	12,271		12,271		12,271			14	
15	Other (specify):*											15	
16	TOTAL Health Care and Programs	4,781,382	254,490	55,452	5,091,324		5,091,324	600	5,091,924			16	
	C. General Administration												
17	Administrative	238,131		592,900	831,031		831,031	(573,972)	257,059			17	
18	Directors Fees											18	
19	Professional Services			76,926	76,926		76,926	(2,325)	74,601			19	
20	Dues, Fees, Subscriptions & Promotions			61,026	61,026		61,026	(14,822)	46,204			20	
21	Clerical & General Office Expenses	100,915	28,832	216,541	346,288		346,288	119,266	465,554			21	
22	Employee Benefits & Payroll Taxes			732,396	732,396		732,396	29,732	762,128			22	
23	Inservice Training & Education											23	
24	Travel and Seminar			8,167	8,167		8,167	4,281	12,448			24	
25	Other Admin. Staff Transportation			12,408	12,408		12,408	6,399	18,807			25	
26	Insurance-Prop.Liab.Malpractice			412,981	412,981		412,981	516	413,497			26	
27	Other (specify):*											27	
28	TOTAL General Administration	339,046	28,832	2,113,345	2,481,223		2,481,223	(430,925)	2,050,298			28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,881,230	589,160	2,474,767	8,945,157		8,945,157	(442,554)	8,502,603			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			38,743	38,743		38,743	1,794	40,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,207	182,207		182,207	(247)	181,960			32
33	Real Estate Taxes			141,600	141,600		141,600	62	141,662			33
34	Rent-Facility & Grounds			1,497,000	1,497,000		1,497,000	9,692	1,506,692			34
35	Rent-Equipment & Vehicles			57,040	57,040		57,040	863	57,903			35
36	Other (specify):*											36
37	TOTAL Ownership			1,916,590	1,916,590		1,916,590	12,164	1,928,754			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		341,395	410,464	751,859		751,859		751,859			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			705,492	705,492		705,492		705,492			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		341,395	1,115,956	1,457,351		1,457,351		1,457,351			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,881,230	930,555	5,507,313	12,319,098		12,319,098	(430,390)	11,888,708			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	(12,155)	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	(247)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(74)	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	(55,531)	21		18
19	Entertainment	(2,074)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,741)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,781)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,386)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,989)		\$	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)	(324,401)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (324,401)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (430,390)		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	\$ (4,248)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	To Eliminate Gifts & Flowers	(4,655)	20	3
4	To Offset Medical Records Income	(466)	10	4
5	To Eliminate Excess IDPH Fees	(1,017)	20	5
6				6
7				7
8				8
9				9
10				10
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12				12
13				13
14				14
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,386)		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.
		Helia Healthcare of Energy	Energy, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Olney	Olney, IL	Bridgemark Employee	St. Ann, MO	Human Resources
		Hillside Rehab & Care Center	Yorkville, IL	Palladian Management	O'Fallon, IL	Nursing/Billing Co.
		Helia Healthcare of Jerseyville	Jerseyville, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Asstd Liv/MemCare
		Helia Healthcare of Hillsboro	Hillsboro, 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%	\$ 1,066	\$ 1,066	1
2	V	17	Management Fees	592,900	Bridgemark Healthcare, LLC	100.00%	18,928	(573,972)	2
3	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	16,416	16,416	3
4	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,879	1,879	4
5	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	176,871	176,871	5
6	V	22	Emp. Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	29,732	29,732	6
7	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,281	4,281	7
8	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	6,399	6,399	8
9	V	26	Isnurance		Bridgemark Healthcare, LLC	100.00%	516	516	9
10	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,794	1,794	10
11	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	62	62	11
12	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	9,692	9,692	12
13	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	863	863	13
14	Total			\$ 592,900			\$ 268,499	\$ * (324,401)	14

* 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 Florissant	Florissant, MO				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	Poplar Bluff, MO				5
6			Helia Richland Healthcare, LLC	Olney, IL				6
7			Helia Healthcare of Newton	Newton, IL				7
8			Palladian Taylorville SNF	Taylorville, IL				8
9			Palladian Mt. Vernon SNF	Mt. Vernon, IL				9
10			Palladian Aviston SNF	Aviston, IL				10
11			Palladian Ucity Manor, LLC	St. Louis, MO				11
12			Palladian Creve Coeur, LLC	St. Louis, MO				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	256,072	3.44	6.88	Distribution	\$ 18,928	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	\$ 18,928		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare # 0048587 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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing & Medical Rec Salaries	Resident Days	501,356	17	\$ 15,484	\$	34,507	\$ 1,066	1
2	17	Owner's Compensation	Resident Days	501,356	17	275,000		34,507	18,928	2
3	19	Professional Fees	Resident Days	501,356	17	238,508		34,507	16,416	3
4	20	Dues & Subscriptions	Resident Days	501,356	17	27,301		34,507	1,879	4
5	21	Salaries - Other	Resident Days	501,356	17	2,420,036	2,420,036	34,507	166,565	5
6	21	Clerical & Office Supplies	Resident Days	501,356	17	149,739		34,507	10,306	6
7	22	Emp. Benefits & Payroll Taxes	Resident Days	501,356	17	431,982		34,507	29,732	7
8	24	Seminars	Resident Days	501,356	17	62,195		34,507	4,281	8
9	25	Admin Staff Travel	Resident Days	501,356	17	92,967		34,507	6,399	9
10	26	Insurance	Resident Days	501,356	17	7,490		34,507	516	10
11	30	Depreciation	Resident Days	501,356	17	26,061		34,507	1,794	11
12	33	Real Estate Taxes	Resident Days	501,356	17	905		34,507	62	12
13	34	Building Rent	Resident Days	501,356	17	111,678		34,507	7,686	13
14	34	Rental - Storage Unit	Resident Days	501,356	17	29,142		34,507	2,006	14
15	35	Equipment Rental	Resident Days	501,356	17	12,543		34,507	863	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		\$ 268,499	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.	182,207	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 182,207	9
	B. Non-Facility Related*												
10	Interest Income Offset											(247)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (247)	14
15	TOTALS (line 9+line14)						\$					\$ 181,960	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.				\$	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.)				\$	141,6002
3. Under or (over) accrual (line 2 minus line 1).				\$	141,6003
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.					
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.				\$	141,6007
Assessed Value from Real Estate Tax Bill:	2024	3,181,346	8		
Real Estate Tax Bill for Calendar Year:	2020	83,815	9		
	2021	86,229	10		
	2022	89,538	11		
	2023	97,541	12		
	2024	93,235	13		
141,600 Line 7, Real Estate Portion of Lease Payment					
62 Bridgemark Healthcare Allocation					
141,662 Total Schedule V, Line 33					
				</	

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 Southbelt Healthcare COUNTY Saint Clair

FACILITY IDPH LICENSE NUMBER 0048587

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. 08-28.0-403-066	LOT/SEC-58PT LT 58	\$ 616.98	\$ 616.98
2. 08-28.0-403-056	LOT/SEC-59PT LOTS 57&58	\$ 5,756.00	\$ 5,756.00
3. 08-28.0-403-004	LOT/SEC-4 PT LYG S OF RICH CR	\$	\$
4. 08-28.0-403-003	LOT/SEC-3 PT LYG S OF RICH CR	\$ 57.26	\$ 57.26
5. 08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	\$ 117.40	\$ 117.40
6. 08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	\$ 378.92	\$ 378.92
7. 08-28.0-403-055	LOT/SEC-58 PT LTS 57&58	\$ 86,308.42	\$ 86,308.42
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 93,234.98	\$ 93,234.98

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: 51,562 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. 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	Section N/A			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire Department Connection			2008	1,685		10			1,685	9
10	Metro Lock Security & Fire Alarm Door Holders			2009	2,614		10			2,614	10
11	Water Heater			2009	3,443		10			3,443	11
12	Kitchen Floor			2009	1,799		10			1,799	12
13	New Compressor			2009	1,647		15			1,647	13
14	Commerical Disposal			2010	1,272		5			1,272	14
15	P-Tee Heat Pump			2010	1,964		10			1,964	15
16	Replace Rooftop A/C Unit			2010	4,481		10			4,481	16
17	2 Victorian Fire Door			2011	2,500	167	15	167		2,375	17
18	22 Fire Doors			2011	6,688	446	15	446		6,354	18
19	Cabinets for New Therapy Room			2012	3,759	251	15	251		3,279	19
20	PTAC Units			2012	956		5			956	20
21	5x5 PCS Gate			2012	630		5			630	21
22	Transformer, Power Supply			2012	2,202		10			2,202	22
23	Hot Water Storage Tank			2012	1,800	90	20	90		1,223	23
24	New Compressor & Rooftop Unit			2012	13,090	872	15	872		11,781	24
25	100 Gallon Natural Gas Water Heater			2012	3,197		10			3,197	25
26	4 PTAC Heater Pumps			2012	2,601		5			2,601	26
27	Hollow Metal Door			2012	5,530	276	20	276		3,618	27
28	Cabinets for New Med Room			2012	2,422	161	15	161		2,113	28
29	New Nurses Station			2012	14,775	985	15	985		12,887	29
30	Relocated Fire Panel			2012	3,389		10			3,389	30
31	Build New Shower Room			2012	17,907	895	20	895		11,714	31
32	Flooring for New ARCH room			2012	23,558		10			23,558	32
33	Arch Wing-Tear out Old Walls & Rebuild New Patient Rooms, Therapy Rooms										33
34	(cont..) Dining Area, Lounge Area & Nurse Office, Drywall Paint, Borders Labor										34
35	(cont..) Doors, Windows, Electrical Lighting Fixtures			2012	159,472	7,974	20	7,974		104,321	35
36	Building Signs			2012	8,449		10			8,449	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 Southbelt Healthcare

0048587

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	Nurses Station ARCH Unit	2013	\$ 5,132	\$ 342	15	\$ 342	\$	\$ 4,333	37
38	Carrier Heat Pump & Fan Oil	2013	7,236		10			7,236	38
39	Amana PTAC	2013	1,183		5			1,183	39
40	Bel-O Sales - Labor Replace Heat Exchanger	2014	1,902		5			1,902	40
41	Amana Air Unit	2014	2,522		5			2,522	41
42	CTS Tech - Cabling	2014	1,330		5			1,330	42
43	Installation of Annunciator Panel for all Wings	2014	4,438		10			4,438	43
44	Roof Repair	2014	12,880		10			12,880	44
45	500 Hall Dining Room - Drywall & Paint	2014	1,715		10			1,715	45
46	Vinyl Plank Floor for 200 Hall	2015	3,485	174	10	174		3,485	46
47	Roof Repairs from Storm Damage	2017	3,500	350	10	350		3,063	47
48	Therapy Room Remodel - Cabinets, Vinyl Floor, Entryway Work	2018	6,823	455	15	455		3,260	48
49	PTAC Heat Pump, 9000 Cooling BTU	2018	1,414		5			1,414	49
50	Roofing Membrane	2019	8,895	890	10	890		6,227	50
51	Nurse Call Station Replacement	2019	2,684	268	10	268		1,812	51
52	Amana Digismark Heat Pump	2019	3,878	388	10	388		2,682	52
53	2 HD 2X4'6" Sign Foam Panels w/Painted Graphics	2020	2,724	272	10	272		1,476	53
54	4x8 & 2x8 Double Faced Signs	2021	6,996	1,399	5	1,399		6,530	54
55	Parking Lot Replacement Asphalt, Strip, Seal	2021	29,130	3,641	8	3,641		14,565	55
56	Cooler, Refrigeration System	2022	10,690	1,069	10	1,069		4,009	56
57	New Compressor on Circuit 2	2022	3,107	259	12	259		885	57
58	Rooftop HVAC	2022	9,370	625	15	625		2,134	58
59	Flooring	2022	4,570	305	15	305		1,016	59
60	Flooring Electrical Update	2022	4,534	227	20	227		737	60
61	Infection Control Kiosk	2022	4,019	402	10	402		1,574	61
62	Compressor	2023	13,786	1,149	12	1,149		3,446	62
63	Plumbing Update	2023	2,779	139	20	139		417	63
64	Flooring - 300 Hall	2024	4,216	422	10	422		843	64
65	Electrical Work Throughout Bldg.	2024	29,485	1,966	15	1,966		3,768	65
66	Vinyl Flooring - Raskin Prodigy	2024	5,052	505	10	505		884	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 491,305	\$ 27,364		\$ 27,364	\$	\$ 325,318	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 491,305	\$ 27,364		\$ 27,364	\$	\$ 325,318	1
2									2
3									3
4	Related Party Allocation - Bridgemark Healthcare								4
5	New Office - Logo Signs - NW Plaza	2021	272		10	27	27	113	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 491,577	\$ 27,364		\$ 27,391	\$ 27	\$ 325,431	34

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	\$119,695	\$10,187	\$11,698	\$1,511		\$85,264	71
72	Current Year Purchases	20,323	1,192	1,448	256		1,448	72
73	Fully Depreciated Assets	86,748					86,748	73
74								74
75	TOTALS	\$226,766	\$11,379	\$13,146	\$1,767		\$173,460	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van		2017	\$7,500	\$	\$	\$	4	\$7,500	76
77	2005 Chevy Truck		2017	7,164				4	7,164	77
78										78
79										79
80	TOTALS			\$14,664	\$	\$	\$		\$14,664	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)	\$733,007	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$38,743	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$40,537	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,794	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$513,555	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 Belleville Belt 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:		156		\$1,497,000			3
4	Additions							4
5								5
6	Related Party Allocations				9,692			6
7	TOTAL		156		\$1,506,692			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☒ NOTerms: *

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: \$57,903Description: 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 Southbelt Healthcare
Attachment to Schedule XII B
Equipment Rentals
12/31/2025

Description		
16A	Specialty Bed and Wound Vac Pump Rentals	29,419
16B	Copier & Postage Meter Lease	17,907
16C	Dietary Equipment	-
16D	Rent Other - Shredding Bin	9,714
16E	Related Party Allocation - Bridgemark Healthcare	863
		<u>57,903</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				187,684		187,684	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxy, Wound, Enterals</u>	39, 2					153,711		153,711	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				410,464			410,464	13
14	TOTAL			\$		\$ 410,464	\$ 341,395		\$ 751,859	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (32,512)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 105,900)	1,477,914		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,351		6
7	Other Prepaid Expenses	3,171		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	4,463		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,475,387	\$	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	491,304		15
16	Equipment, at Historical Cost	218,422		16
17	Accumulated Depreciation (book methods)	(493,706)		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 Assets	5,653,805		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,869,825	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,345,212	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 226,552	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	469,706		29
30	Accrued Salaries Payable	377,603		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 Assessments	56,855		36
37	Accrued CMPs	34,707		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,165,423	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Parties	7,303,392		43
44	Lease Liability	5,721,499		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 13,024,891	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,190,314	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,845,102)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,345,212	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,407,423)	1
2	Restatements (describe):		2
3	Prior Year Adjustments	(16,587)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,424,010)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(421,092)	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)	\$ (421,092)	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)	\$ (6,845,102)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Southbelt Healthcare

0048587

Report Period Beginning: 01/01/2025

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	\$ 12,049,507	1
2	Discounts and Allowances for all Levels	(687,426)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,362,081	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	193,381	6
7	Oxygen	7,475	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 200,856	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***	247	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 247	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Quarterly Incentive Payment	315,339	28
28a	Miscellaneous	19,483	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 334,822	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,898,006	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,372,610	31
32	Health Care	5,091,324	32
33	General Administration	2,481,223	33
	B. Capital Expense		
34	Ownership	1,916,590	34
	C. Ancillary Expense		
35	Special Cost Centers	751,859	35
36	Provider Participation Fee	705,492	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,319,098	40
41	Income before Income Taxes (line 30 minus line 40)**	(421,092)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (421,092)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,631,685.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,999,695.00	45
46	MMAI-Medicaid is the Primary Payer	370,634.00	46
47	MMAI-Medicare is the Primary Payer	98,299.00	47
48	Private Pay	754,033.00	48
49	Medicare Part A	2,013,280.00	49
50	Other-(specify) Managed Care	494,455.00	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)	\$ 11,362,081	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			\$	\$	1
2	Assistant Director of Nursing	2,891	2,959	172,314	58.23	2
3	Registered Nurses	8,097	8,166	411,370	50.38	3
4	Licensed Practical Nurses	29,664	30,137	1,368,347	45.40	4
5	CNAs & Orderlies	74,522	75,576	2,027,713	26.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,437	4,521	104,663	23.15	10
11	Social Service Workers	1,377	1,414	41,486	29.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,594	14,730	310,690	21.09	15
16	Dishwashers					16
17	Maintenance Workers	2,220	2,268	107,791	47.53	17
18	Housekeepers	14,568	14,777	305,098	20.65	18
19	Laundry	1,981	2,006	37,223	18.56	19
20	Administrator	2,340	2,387	129,830	54.39	20
21	Assistant Administrator	2,343	2,391	108,301	45.30	21
22	Other Administrative	1,136	1,141	28,153	24.67	22
23	Office Manager	2,202	2,240	72,762	32.48	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: Respiratory Thera	15,476	15,689	655,489	41.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,848	180,402	\$ 5,881,230 *	\$ 32.60	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		\$ 20,186	1, 3	35
36	Medical Director		22,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,894	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		2,754	11, 3	44
45	Social Service Consultant		2,754	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 57,588		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 Southbelt Healthcare

0048587Report Period Beginning:01/01/2025Ending:12/31/2025

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Amy Peterson

Administrator

0

\$ 53,580

Chad Foster

Administrator

0

76,250

Tracie Mittelbuscher

Asst. Admin

0

108,301

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

(List each licensed administrator separately.)

\$ 238,131

B. Administrative - Other

Description

Amount

Bridgemark Healthcare, LLC - Management Fees

\$ 592,900

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

(Attach a copy of any management service agreement)

\$ 592,900

C. Professional Services

Vendor/Payee

Type

Amount

C.J. Schlosser & Company

Accounting Services

\$ 3,825

Sandberg Phoenix

Legal Services

1,500

Polsinelli PC

Legal Services

2,868

Saric Consulting

Medicaid Consulting

4,375

Mathis, Marifian, & Richter LTD

Legal Services - Collections

18,741

Personnel Planners

Unemployment Consulting

1,733

Paylocity

Payroll Processing

43,884

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

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

\$ 76,926

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 141,848

Unemployment Compensation Insurance

25,541

FICA Taxes

445,982

Employee Health Insurance

95,805

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k Match

20,619

Other Employee Benefits

2,601

Related Party Allocations - Bridgemark

29,732

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

\$ 762,128

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

13,126

Health Care Worker Background Check

2,945

(Indicate # of checks performed)

Patient Background Checks

Association Dues (total from pg 22, #4)

13,229

Dues & Subscriptions

10,697

Miscellaneous Licenses & Fees

6,586

Advertising

6,781

Related Party Allocation - Bridgemark

1,879

Less: Public Relations Expense

()

PAC and Lobbying payments

(4,248)

All non-allowable advertising

(6,781)

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

\$ 46,204

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Corporate Hotel

276

Seminar Expense

220

Online Training - Relias

7,671

Related Party Allocation - Bridgemark

4,281

Entertainment Expense

()

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

TOTAL

\$ 12,448

* 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>8,981</u> |
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | |
| | |
| | <u>8,981</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>4,123</u> |
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>125</u> |
| | |
| | |
| | <u>4,248</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>13,104</u> |
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>125</u> |
| | |
| | |
| | <u>13,229</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 37,742 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. \$ 705,492
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? 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.