

		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: 0050310

Facility Name: Hillside Rehab Care Center

Address: 1308 Game Farm Road Yorkville 60560

NumberCityZip Code

County: Kendall

Telephone Number: (630) 553-5811 Fax # (630) 553-2740

HFS ID Number:

Date of Initial License for Current Owners: 01/15/2009

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. TeftellerTelephone Number: (618) 465-7717Email 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 Hillside Rehab Care Center # 0050310 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>79</u>	Skilled (SNF)	<u>79</u>	<u>28,835</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>79</u>	TOTALS	<u>79</u>	<u>28,835</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	3,909	7,520	1,475	133	2,306	1,575	403	17,321	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,909	7,520	1,475	133	2,306	1,575	403	17,321	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 60.07%

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 01/15/2009

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/15/2009 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 79

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.

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	205,168	10,611	6,920	222,699		222,699		222,699			1
2	Food Purchase		114,094		114,094		114,094	(75)	114,019			2
3	Housekeeping	154,840	49,612	1,205	205,657		205,657		205,657			3
4	Laundry			139,536	139,536		139,536		139,536			4
5	Heat and Other Utilities			94,589	94,589		94,589	(8,741)	85,848			5
6	Maintenance	56,012	8,805	44,233	109,050		109,050		109,050			6
7	Other (specify):*											7
8	TOTAL General Services	416,020	183,122	286,483	885,625		885,625	(8,816)	876,809			8
	B. Health Care and Programs											
9	Medical Director			9,400	9,400		9,400		9,400			9
10	Nursing and Medical Records	1,898,760	68,232	15,913	1,982,905		1,982,905	450	1,983,355			10
10a	Therapy											10a
11	Activities	45,796	3,950	5,457	55,203		55,203		55,203			11
12	Social Services	28,090	47	1,838	29,975		29,975		29,975			12
13	CNA Training											13
14	Program Transportation			12,401	12,401		12,401		12,401			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,972,646	72,229	45,009	2,089,884		2,089,884	450	2,090,334			16
	C. General Administration											
17	Administrative	106,622		268,900	375,522		375,522	(259,399)	116,123			17
18	Directors Fees											18
19	Professional Services			84,923	84,923		84,923	(356)	84,567			19
20	Dues, Fees, Subscriptions & Promotions			64,367	64,367		64,367	(24,540)	39,827			20
21	Clerical & General Office Expenses	127,368	17,735	151,900	297,003		297,003	69,542	366,545			21
22	Employee Benefits & Payroll Taxes			273,374	273,374		273,374	14,924	288,298			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,528	9,528		9,528	2,149	11,677			24
25	Other Admin. Staff Transportation			11,010	11,010		11,010	3,212	14,222			25
26	Insurance-Prop.Liab.Malpractice			168,696	168,696		168,696	259	168,955			26
27	Other (specify):*											27
28	TOTAL General Administration	233,990	17,735	1,032,698	1,284,423		1,284,423	(194,209)	1,090,214			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,622,656	273,086	1,364,190	4,259,932		4,259,932	(202,575)	4,057,357			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			20,323	20,323		20,323	900	21,223			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			97,000	97,000		97,000	(179)	96,821			32
33	Real Estate Taxes			63,600	63,600		63,600	31	63,631			33
34	Rent-Facility & Grounds			391,674	391,674		391,674	4,865	396,539			34
35	Rent-Equipment & Vehicles			62,863	62,863		62,863	433	63,296			35
36	Other (specify):*											36
37	TOTAL Ownership			635,460	635,460		635,460	6,050	641,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,253	317,050	448,303		448,303		448,303			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,057	279,057		279,057		279,057			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		131,253	596,107	727,360		727,360		727,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,622,656	404,339	2,595,757	5,622,752		5,622,752	(196,525)	5,426,227			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,741)	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	(179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	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	(470)	20		17
18	Fines and Penalties	(16,307)	21		18
19	Entertainment	(2,932)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,596)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,739)	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	(6,359)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,398)		\$	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)	(134,127)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (134,127)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (196,525)		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	\$ (2,151)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	To Eliminate Gifts & Flowers	(4,123)	20	3
4	To Offset Medical Records Income	(85)	10	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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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	(6,359)		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
		Helia Southbelt Healthcare	Belleville, IL	Palladian Management	O'Fallon, IL	Nursing/Billing Co.
		Helia Healthcare of Jerseyville	Jerseyville, IL	Palladian Taylorville A	Taylorville, IL	Assisted Living
		Helia Healthcare of Newton	Newton, IL	Palladian Mt. Vernon	Mt. Vernon, 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%	\$ 535	\$ 535	1
2	V	17	Management Fees	268,900	Bridgemark Healthcare, LLC	100.00%	9,501	(259,399)	2
3	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	8,240	8,240	3
4	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	943	943	4
5	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	88,781	88,781	5
6	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	14,924	14,924	6
7	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,149	2,149	7
8	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,212	3,212	8
9	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	259	259	9
10	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	900	900	10
11	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	31	31	11
12	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	4,865	4,865	12
13	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	433	433	13
14	Total			\$ 268,900			\$ 134,773	\$ * (134,127)	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 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			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				6
7			Helia Richland Healthcare	Olney, IL				7
8			Palladian Aviston SNF	Aviston, IL				8
9			Palladian Mt. Vernon SNF	Mt. Vernon, IL				9
10			Palladian Taylorville SNF	Taylorville, IL				10
11			Palladian Ucity Manor, LLC	St. Louis, MO				11
12			Palladian Creve Coeur, LLC	St. Louis, MO				12
13								13
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	265,499	1.73	3.45	Distribution	\$ 9,501	17, 8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,501		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab Care Center # 0050310 Report Period Beginning: 01/01/2025 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	\$	17,321	\$ 535	1
2	17	Owner's Compensation	Resident Days	501,356	17	275,000		17,321	9,501	2
3	19	Professional Fees	Resident Days	501,356	17	238,508		17,321	8,240	3
4	20	Dues & Subscriptions	Resident Days	501,356	17	27,301		17,321	943	4
5	21	Salaries - Other	Resident Days	501,356	17	2,420,036	2,420,036	17,321	83,608	5
6	21	Clerical & Office Supplies	Resident Days	501,356	17	149,739		17,321	5,173	6
7	22	Emp. Benefits & Payroll Taxes	Resident Days	501,356	17	431,982		17,321	14,924	7
8	24	Seminars	Resident Days	501,356	17	62,195		17,321	2,149	8
9	25	Admin Staff Travel	Resident Days	501,356	17	92,967		17,321	3,212	9
10	26	Insurance	Resident Days	501,356	17	7,490		17,321	259	10
11	30	Depreciation	Resident Days	501,356	17	26,061		17,321	900	11
12	33	Real Estate Taxes	Resident Days	501,356	17	905		17,321	31	12
13	34	Building Rent	Resident Days	501,356	17	111,678		17,321	3,858	13
14	34	Rental - Storage Unit	Resident Days	501,356	17	29,142		17,321	1,007	14
15	35	Equipment Rental	Resident Days	501,356	17	12,543		17,321	433	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		\$ 134,773	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap Funding IV Trust		X	Line of Credit		10/22/09				Var.		97,000	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 97,000	9
	B. Non-Facility Related*												
10	Interest Income Offset											(179)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (179)	14
15	TOTALS (line 9+line14)						\$					\$ 96,821	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.)				\$63,600	2
3. Under or (over) accrual (line 2 minus line 1).				\$63,600	3
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.				\$63,600	7
Assessed Value from Real Estate Tax Bill:	2024	505,630	8		
Real Estate Tax Bill for Calendar Year:	2020	60,864	9		
	2021	35,473	10		
	2022	44,574	11		
	2023	43,930	12		
	2024	41,066	13		
63,600 Line 7, Real Estate Tax Portion of Lease Payment					
31 Related Party Allocation - Bridgemark					
63,631 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 Hillside Rehab Care Center COUNTY Kendall

FACILITY IDPH LICENSE NUMBER 0050310

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. 02-29-278-019	Lot 1 Unit 13 Countryside Sub	\$ 31,220.70	\$ 31,220.70
2. 02-29-278-020	Sec 29-37-7	\$ 6,650.16	\$ 6,650.16
3. 02-29-278-018	Lot 12 Unit 1 & Lot 16 Unit 2	\$ 3,195.10	\$ 3,195.10
4.	Countryside Sub	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 41,065.96	\$ 41,065.96

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,390 B. General Construction Type: Exterior Masonry Frame 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).
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.

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

Facility Name & ID Number Hillside Rehab Care Center

0050310

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Therapy Door			2009	1,630		15			1,630	9
10	Wall Covering, Shower Room Remodel, Nurses Station & Entryway			2009	15,951		15			15,951	10
11	Concrete			2009	3,500		15			3,500	11
12	Hallway Wing 1 - Paint, Crown Molding			2010	5,752	32	15	32		5,752	12
13	Oakwell Cabinets for Nurses Station			2010	1,163	13	15	13		1,163	13
14	Reception Area - Countertop, Oakwork, Drywall			2010	5,127	114	15	114		5,127	14
15	Shower Room W1 Heater, Fire System Installation			2010	2,854	64	15	64		2,854	15
16	Shower Room W1 Heater, Fire System Installation			2010	2,854	64	15	64		2,854	16
17	4 Ton A/C Unit & Install			2010	3,155		10			3,155	17
18	Concrete Work (Drainage; W1, W2, Main)			2010	7,000	350	20	350		5,367	18
19	Hallway Wing 2 - Paint, Crown Molding			2010	4,836	215	15	215		4,836	19
20	Facility Signage in Building			2010	3,725		10			3,725	20
21	Dining Room - Paint, Tile, Lights/Blinds			2010	3,426	190	15	190		3,426	21
22	Beauty Show-Crown Molding, Carpet, Tile, Cabinets, Light Fixtures			2011	2,648	177	15	177		2,648	22
23	Garage - Flooring, Electrical Work, Drywall Installation, Paint			2011	6,873	458	15	458		6,759	23
24	Fire Rated Doors & Fire Alarm Control Panel			2011	25,494	88	15	88		25,465	24
25	Water Heater			2012	1,365		10			1,365	25
26	Fans for ARCH Units			2013	1,153		10			1,153	26
27	Blinds for ARCH Units			2013	1,820		5			1,820	27
28	Hillside Welcome Sign			2013	1,290		10			1,290	28
29	Cabinets for ARCH Unit			2013	2,843	190	15	190		2,338	29
30	Drapes/Paint for ARCH Unit			2013	4,880		5			4,880	30
31	Flooring/Sink/Mirror for ARCH Unit			2013	6,011		10			6,011	31
32	Materials/Labor/Supplies for ARCH Unit			2013	32,364	2,158	15	2,158		26,611	32
33	Vanities/Shower/Plumbing			2013	6,004	300	20	300		3,628	33
34	Doors for ARCH Unit			2013	4,053	270	15	270		3,332	34
35	Air Conditioner			2013	2,010		10			2,010	35
36											36

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

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

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

Facility Name & ID Number Hillside Rehab Care Center

0050310

Report Period Beginning:

01/01/2025 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	Valances, Paint, Wall Coverings, Exit Lights, New Walls, Floor		\$	\$		\$	\$	\$	37
38	(cont..) Finishes, Window for New Therapy Room	2014	12,814	854	15	854		10,049	38
39	Cabinets for Therapy Room	2014	2,306	154	15	154		1,768	39
40	Flooring in New Dining Room	2014	1,261	84	15	84		960	40
41	Windows & Wall Covering for Kitchen Remodel	2014	2,295	153	15	153		1,721	41
42	New Windows	2014	1,765		10			1,765	42
43	2 A/C Units	2014	1,650		5			1,650	43
44	New Flooring for Wing 1 & Wing 2	2015	4,020	268	15	268		2,791	44
45	Water Heater	2016	5,800	580	10	580		5,655	45
46	Finishing Touches on ARCH Unit & Therapy Room - Trim								46
47	(cont..) Painting, etc.	2016	29,250	1,950	15	1,950		19,500	47
48	Carpet	2018	2,389		5			2,389	48
49	ARCH Hallway Carpet	2018	2,173		5			2,173	49
50	Flooring - Mod Tile Timber Grove	2019	3,894	389	10	389		2,661	50
51	14 Dry Pendants	2019	5,107	340	15	340		2,185	51
52	78x84 Non Illuminated Mounment Sign	2020	8,665	866	10	866		4,838	52
53	A/C Unit	2020	4,300	430	10	430		2,293	53
54	A/C Unit	2021	6,566	657	10	657		3,009	54
55	Kitchen Exterior Entry Door	2022	4,496	225	20	225		862	55
56	3 Ton Armstrong Air	2023	4,218	843	5	843		2,179	56
57	Replace 10' of Dry Sprinkler System	2024	4,535	454	10	454		605	57
58	Sprinkler System Accelerator	2024	4,752	475	10	475		594	58
59									59
60									60
61	Related Party Allocation - Bridgemark								61
62	New Office - Logo Signs - NW Plaza	2021	136		10	14	14	57	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 272,173	\$ 13,405		\$ 13,419	\$ 14	\$ 218,354	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$70,609	\$6,514	\$7,272	\$758		\$41,783	71
72	Current Year Purchases	5,735	404	532	128		532	72
73	Fully Depreciated Assets	100,469					100,469	73
74								74
75	TOTALS	\$176,813	\$6,918	\$7,804	\$886		\$142,784	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Section N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$448,986	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$20,323	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$21,223	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$900	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$361,138	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 Yorkville 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:		79		\$381,960			3
4	Additions							4
5	Storage Rental				9,714			5
6	Related Party Allocation				4,865			6
7	TOTAL		79		\$396,539			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: \$63,296Description: 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.

Hillside Rehab & Care Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2025

Description		
16A	Nursing Equipment	54,627
16B	Copier Lease	8,117
16C	Related Party Allocation - Bridgemark Healthcare	433
16D	Respiratory Equipment Rental	119
		<u>63,296</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				109,616		109,616	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					21,637		21,637	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				317,050			317,050	13
14	TOTAL			\$		\$ 317,050	\$ 131,253		\$ 448,303	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	\$ (10,695)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,000))	413,398		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,174		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	2,244		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 409,121	\$	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	264,588		15
16	Equipment, at Historical Cost	172,714		16
17	Accumulated Depreciation (book methods)	(351,176)		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: <u>Right of Use Asset</u>)	3,499,490		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,585,616	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,994,737	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 246,160	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	154,158		29
30	Accrued Salaries Payable	101,146		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	<u>Accrued Provider Taxes</u>	22,295		36
37	<u>Accrued CMPs</u>	10,970		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 534,729	\$	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	<u>Due to Related Parties</u>	3,728,063		43
44	<u>Lease Liability</u>	3,541,390		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,269,453	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,804,182	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,809,445)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,994,737	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,316,332)	1
2	Restatements (describe):		2
3	Prior Year Adjustments	(7,759)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,324,091)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(485,354)	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)	\$ (485,354)	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)	\$ (3,809,445)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab Care Center

0050310

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,672,821	1
2	Discounts and Allowances for all Levels	(712,190)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,960,631	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	163,865	6
7	Oxygen	1,943	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,808	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***	179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 179	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Quarterly Incentive Payment	8,048	28
28a	Miscellaneous	2,732	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,780	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,137,398	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	885,625	31
32	Health Care	2,089,884	32
33	General Administration	1,284,423	33
	B. Capital Expense		
34	Ownership	635,460	34
	C. Ancillary Expense		
35	Special Cost Centers	448,303	35
36	Provider Participation Fee	279,057	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,622,752	40
41	Income before Income Taxes (line 30 minus line 40)**	(485,354)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (485,354)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 876,443.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,686,071.00	45
46	MMAI-Medicaid is the Primary Payer	330,712.00	46
47	MMAI-Medicare is the Primary Payer	76,673.00	47
48	Private Pay	505,382.00	48
49	Medicare Part A	1,253,027.00	49
50	Other-(specify) Managed Care	232,323.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,960,631	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	1,907	1,924	\$ 109,647	\$ 56.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,563	9,621	460,300	47.84	3
4	Licensed Practical Nurses	9,222	9,345	428,253	45.83	4
5	CNAs & Orderlies	33,987	34,337	900,560	26.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,012	2,057	45,796	22.26	10
11	Social Service Workers	1,011	1,018	28,090	27.59	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,015	45,831	22.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,915	7,056	159,337	22.58	15
16	Dishwashers					16
17	Maintenance Workers	2,054	2,054	56,012	27.27	17
18	Housekeepers	7,584	7,728	154,840	20.04	18
19	Laundry					19
20	Administrator	2,221	2,259	106,622	47.20	20
21	Assistant Administrator					21
22	Other Administrative	1,260	1,283	58,473	45.58	22
23	Office Manager	2,120	2,156	68,895	31.96	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)	81,840	82,853	\$ 2,622,656 *	\$ 31.65	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		\$ 6,920	1, 3	35
36	Medical Director		9,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,616	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,838	11, 3	44
45	Social Service Consultant		1,838	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,612		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	45	2,413	10, 3	52
53	TOTAL (lines 50 - 52)	45	\$ 2,413		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
Angel Ness	Administrator	0	\$ 106,622	Workers' Compensation Insurance		\$ 42,052	IDPH License Fee	\$ 1,990
				Unemployment Compensation Insurance		12,886	Advertising: Employee Recruitment	12,866
				FICA Taxes		200,630	Health Care Worker Background Check	1,624
				Employee Health Insurance		6,885	(Indicate # of checks performed _____)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	6,699
				401k Match		10,021	Dues & Subscriptions	16,584
				Employee Benefits		900	Miscellaneous Licenses & Fees	1,272
							Advertising	18,739
							Related Party Allocation - Bridgemark	943
							Less: Public Relations Expense	()
							PAC and Lobbying payments	(2,151)
							All non-allowable advertising	(18,739)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 39,827
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other								
Description			Amount	Description			Amount	
Bridgemark Healthcare, LLC - Management Fees			\$ 268,900	Related Party Allocations - Bridgemark			14,924	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 268,900	TOTAL (agree to Schedule V, line 22, col.8)			\$ 288,298	
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount		
C.J. Schlosser & Company	Accounting Services		\$ 3,825	Section N/A		\$	Out-of-State Travel	
Much Shelist	Legal Fees		36,878					
Mathis, Marifian & Richter, LTD	Collection Fees		8,596					
Saric Consulting	Medicaid Consulting		14,111				In-State Travel	
Personnel Planners	Unemployment Consulting		1,733					
Paylocity	Payroll Processing		19,780					
							Seminar Expense	
							Online Training - Relias	
							Related Party Allocations - Bridgemark	
							Entertainment Expense	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)	
			\$ 84,923				TOTAL	\$ 11,677

*** 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>IL HEALTHCARE ASSOCIATION (IHCA)</u> | |
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>4,548</u> |
| | |
| | <u>4,548</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>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>63</u> |
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>2,088</u> |
| | |
| | <u>2,151</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>63</u> |
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>6,636</u> |
| | |
| | <u>6,699</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 22,399 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. \$ 279,057
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.