

		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: 0056671

Facility Name: Richland Nursing Rehab

Address: 900 East Scott St Olney 62450
Number City Zip Code

County: Richland

Telephone Number: (618) 395-1000 Fax # (618) 392-3836

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2020

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☒	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

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, LLC 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 Richland Nursing Rehab # 0056671 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>157</u>	Skilled (SNF)	<u>157</u>	<u>57,305</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>157</u>	TOTALS	<u>157</u>	<u>57,305</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	<u>2,977</u>	<u>20,089</u>	<u>1,600</u>	<u>42</u>	<u>2,798</u>	<u>1,098</u>	<u>68</u>	<u>28,672</u>	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	<u>2,977</u>	<u>20,089</u>	<u>1,600</u>	<u>42</u>	<u>2,798</u>	<u>1,098</u>	<u>68</u>	<u>28,672</u>	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 50.03%

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 07/01/2020

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 07/01/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 157

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Richland Nursing Rehab # 0056671 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	278,987	24,949	12,603	316,539		316,539		316,539			1
2	Food Purchase		208,010		208,010		208,010	(100)	207,910			2
3	Housekeeping	221,170	20,949	450	242,569		242,569		242,569			3
4	Laundry	57,494	9,656		67,150		67,150		67,150			4
5	Heat and Other Utilities			177,383	177,383		177,383	(9,712)	167,671			5
6	Maintenance	66,939	35,611	100,109	202,659		202,659		202,659			6
7	Other (specify):*											7
8	TOTAL General Services	624,590	299,175	290,545	1,214,310		1,214,310	(9,812)	1,204,498			8
	B. Health Care and Programs											
9	Medical Director			37,200	37,200		37,200		37,200			9
10	Nursing and Medical Records	2,237,854	96,622	688,521	3,022,997		3,022,997	477	3,023,474			10
10a	Therapy		3,031		3,031		3,031		3,031			10a
11	Activities	100,373	14,841	7,383	122,597		122,597		122,597			11
12	Social Services	58,248		2,145	60,393		60,393		60,393			12
13	CNA Training											13
14	Program Transportation			2,984	2,984		2,984		2,984			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,396,475	114,494	738,233	3,249,202		3,249,202	477	3,249,679			16
	C. General Administration											
17	Administrative	188,653		373,300	561,953		561,953	(357,573)	204,380			17
18	Directors Fees											18
19	Professional Services			56,646	56,646		56,646	13,640	70,286			19
20	Dues, Fees, Subscriptions & Promotions			65,937	65,937		65,937	(27,117)	38,820			20
21	Clerical & General Office Expenses	109,314	15,181	370,990	495,485		495,485	(72,730)	422,755			21
22	Employee Benefits & Payroll Taxes			392,426	392,426		392,426	24,705	417,131			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,962	8,962		8,962	3,557	12,519			24
25	Other Admin. Staff Transportation			6,718	6,718		6,718	5,317	12,035			25
26	Insurance-Prop.Liab.Malpractice			223,011	223,011		223,011	428	223,439			26
27	Other (specify):*											27
28	TOTAL General Administration	297,967	15,181	1,497,990	1,811,138		1,811,138	(409,773)	1,401,365			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,319,032	428,850	2,526,768	6,274,650		6,274,650	(419,108)	5,855,542			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			12,510	12,510		12,510	1,490	14,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,254	8,254		8,254	(395)	7,859			32
33	Real Estate Taxes			41,729	41,729		41,729	52	41,781			33
34	Rent-Facility & Grounds			679,800	679,800		679,800	8,054	687,854			34
35	Rent-Equipment & Vehicles			13,209	13,209		13,209	717	13,926			35
36	Other (specify):*											36
37	TOTAL Ownership			755,502	755,502		755,502	9,918	765,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,093	311,943	390,036		390,036		390,036			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			598,376	598,376		598,376		598,376			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		78,093	910,319	988,412		988,412		988,412			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,319,032	506,943	4,192,589	8,018,564		8,018,564	(409,190)	7,609,374			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	(9,712)	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	(395)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(100)	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	(400)	20		17
18	Fines and Penalties	(214,640)	21		18
19	Entertainment	(5,052)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,880)	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	(10,807)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (258,986)		\$	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)	(150,204)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (150,204)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (409,190)		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	\$ (4,275)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	To Eliminate Gifts & Flowers	(6,952)	20	3
4	To Offset Medical Records Income	(409)	10	4
5	To Add IDPH Fees Paid in Prior Year	829	20	5
6				6
7				7
8				8
9				9
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,807)		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 Southbelt Healthcare	Belleville, 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 Taylorville A	Taylorville, IL	Assisted Living
		Helia Healthcare of Hillsboro	Hillsboro, 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%	\$ 886	\$ 886	1
2	V	17	Management Fees	373,300	Bridgemark Healthcare, LLC	100.00%	15,727	(357,573)	2
3	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	13,640	13,640	3
4	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,561	1,561	4
5	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	146,962	146,962	5
6	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,705	24,705	6
7	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,557	3,557	7
8	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,317	5,317	8
9	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	428	428	9
10	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,490	1,490	10
11	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	52	52	11
12	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	8,054	8,054	12
13	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	717	717	13
14	Total			\$ 373,300			\$ 223,096	\$ * (150,204)	14

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

Ownership Listing-1

ID# 0056671

01/01/2025

Bridgemark Healthcare

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

Operator/Licensee

-Names of trust beneficiaries must be listed.

Place of Residence

Ownership

Ownership

Ownership

Ownership

Ownership

[illegible]

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 Olney	Olney, IL				1
2			Helia Healthcare of Effingham	Effingham, IL				2
3			Helia Healthcare of Salem	Salem, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6			Palladian Aviston SNF	Aviston, IL				6
7			Palladian Mt. Vernon SNF	Mt. Vernon, IL				7
8			Palladian Taylorville SNF	Taylorville, IL				8
9			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				9
10			Helia Healthcare of Newton	Newton, 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	259,273	2.86	5.72	Distribution	\$ 15,727	17, 8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,727		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 Richland Nursing Rehab # 0056671 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 Saint 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	\$	28,672	\$ 886	1
2	17	Owner's Compensation	Resident Days	501,356	17	275,000		28,672	15,727	2
3	19	Professional Fees	Resident Days	501,356	17	238,508		28,672	13,640	3
4	20	Dues & Subscriptions	Resident Days	501,356	17	27,301		28,672	1,561	4
5	21	Salaries - Other	Resident Days	501,356	17	2,420,036	2,420,036	28,672	138,399	5
6	21	Clerical & Office Supplies	Resident Days	501,356	17	149,739		28,672	8,563	6
7	22	Emp Benefits & Payroll Taxes	Resident Days	501,356	17	431,982		28,672	24,705	7
8	24	Seminars	Resident Days	501,356	17	62,195		28,672	3,557	8
9	25	Admin Staff Travel	Resident Days	501,356	17	92,967		28,672	5,317	9
10	26	Insurance	Resident Days	501,356	17	7,490		28,672	428	10
11	30	Depreciation	Resident Days	501,356	17	26,061		28,672	1,490	11
12	33	Real Estate Taxes	Resident Days	501,356	17	905		28,672	52	12
13	34	Building Rent	Resident Days	501,356	17	111,678		28,672	6,387	13
14	34	Rental - Storage Unit	Resident Days	501,356	17	29,142		28,672	1,667	14
15	35	Equipment Rental	Resident Days	501,356	17	12,543		28,672	717	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		\$ 223,096	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.	8,254	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 8,254	9
	B. Non-Facility Related*												
10	Interest Income Offset											(395)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (395)	14
15	TOTALS (line 9+line14)						\$					\$ 7,859	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.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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.)				\$	41,7292
3. Under or (over) accrual (line 2 minus line 1).				\$	41,7293
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.				\$	41,7297
Assessed Value from Real Estate Tax Bill:	2024	664,845	8		
Real Estate Tax Bill for Calendar Year:	2020	82,661	9		
	2021	83,503	10		
	2022	83,265	11		
	2023	79,520	12		
	2024	50,485	13		
41,729 Line 7 Real Estate Tax Portion of Lease Payment					
52 Related Party Allocation - Bridgemark					
41,781 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

FACILITY NAME Richland Nursing Rehab COUNTY Richland
FACILITY IDPH LICENSE NUMBER 0056671
CONTACT PERSON REGARDING THIS REPORT Jason Mills
TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

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.

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.)

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 provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,617 B. General Construction Type: Exterior Brick Frame Wood Number of Stories

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

Facility Name & ID Number Richland Nursing Rehab

0056671

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	Vinyl & Carpet Flooring - Sitting Area			2021	9,185	918	10	918		4,516
10	New Canopy Install			2021	4,031	269	15	269		1,142
11	Replaced Boiler Popoff & Gas Valves - West & East Dining Rooms			2021	3,596	240	15	240		979
12	2 Ton A/C, Evaporator Coil and Pad			2023	5,100	1,020	5	1,020		2,465
13	Fire Panel			2023	23,500	2,350	10	2,350		4,896
14	Outdoor Coil and Compressor			2023	10,750	716	15	716		1,493
15	New Compressor			2025	3,247	270	10	270		270
16	New Compressor in Delta System			2025	2,565	171	10	171		171
17	East addition sprinkler system flushed			2025	17,433	872	15	872		872
18	Replace all dry pendant sprinklers - West Bldg			2025	62,800	628	25	628		628
19										19
20										20
21	Related Party Allocation - Bridgemark Healthcare:									21
22	New Office - Logo Signs - NW Plaza			2021	226		10	23	23	94
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										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

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	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 142,433	\$ 7,454		\$ 7,477	\$ 23	\$ 17,526	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	\$ 38,432	\$ 3,151	\$ 4,406	\$ 1,255		\$ 18,739	71
72	Current Year Purchases	29,390	1,905	2,117	212		2,117	72
73	Fully Depreciated Assets	46,123					46,123	73
74								74
75	TOTALS	\$ 113,945	\$ 5,056	\$ 6,523	\$ 1,467		\$ 66,979	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)	\$ 256,378	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,510	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,000	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,490	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 84,505	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 Olney Scott Strt Prop 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:		157		\$ 679,800			3
4	Additions							4
5								5
6	Related Party Allocation - Bridgemark				8,054			6
7	TOTAL		157		\$ 687,854			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

N/A
9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 13,926 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Helia Richland Healthcare, LLC
Attachment to Schedule XII B
Equipment Rental
12/31/2025

Description		
16A	Nursing Equipment Rental	3,821
16B	Copier Lease	2,623
16C	Respiratory Equipment Rental	6,765
16D	Related Party Allocation - Bridgemark	717
		<u>13,926</u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

		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.

(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				40,093		40,093	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound Care, Enterals</u>	39, 2					38,000		38,000	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				311,943			311,943	13
14	TOTAL			\$		\$ 311,943	\$ 78,093		\$ 390,036	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	\$ (53,566)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,500))	387,459		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,983		7
8	Accounts Receivable (owners or related parties)	3,184,776		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,522,652	\$	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	142,205		15
16	Equipment, at Historical Cost	94,828		16
17	Accumulated Depreciation (book methods)	(68,016)		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): <u>Right of Use Asset</u>	6,548,182		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,717,199	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,239,851	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 444,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,677		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 Assessment</u>	47,875		36
37	<u>Accrued CMP Penalties</u>	19,691		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 674,925	\$	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>Lease Liability</u>	6,627,122		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,627,122	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,302,047	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,937,804	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,239,851	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,377,048	1
2	Restatements (describe):		2
3	Prior Year Adjustment	(2,125)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,374,923	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(437,119)	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)	\$ (437,119)	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)	\$ 2,937,804	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Richland Nursing Rehab

0056671

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	\$ 7,685,181	1
2	Discounts and Allowances for all Levels	(479,408)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,205,773	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,927	6
7	Oxygen	24,603	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 265,530	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	100	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)	\$ 100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	395	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 395	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Quarterly Incentive Payments	109,238	28
28a	Miscellaneous	409	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 109,647	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,581,445	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,214,310	31
32	Health Care	3,249,202	32
33	General Administration	1,811,138	33
	B. Capital Expense		
34	Ownership	755,502	34
	C. Ancillary Expense		
35	Special Cost Centers	390,036	35
36	Provider Participation Fee	598,376	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,018,564	40
41	Income before Income Taxes (line 30 minus line 40)**	(437,119)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (437,119)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 680,580.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,592,600.00	45
46	MMAI-Medicaid is the Primary Payer	365,780.00	46
47	MMAI-Medicare is the Primary Payer	26,032.00	47
48	Private Pay	753,554.00	48
49	Medicare Part A	745,080.00	49
50	Other-(specify) Managed Care	42,147.00	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)	\$ 7,205,773	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	1,947	1,980	\$ 93,551	\$ 47.25	1
2	Assistant Director of Nursing	753	777	33,005	42.48	2
3	Registered Nurses	9,863	10,068	422,143	41.93	3
4	Licensed Practical Nurses	10,677	10,782	399,416	37.04	4
5	CNAs & Orderlies	52,712	53,285	1,289,739	24.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,141	5,206	100,373	19.28	10
11	Social Service Workers	1,920	1,947	58,248	29.92	11
12	Dietician					12
13	Food Service Supervisor	4,057	4,075	98,725	24.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,356	11,452	180,262	15.74	15
16	Dishwashers					16
17	Maintenance Workers	2,103	2,133	66,939	31.38	17
18	Housekeepers	12,778	12,949	221,170	17.08	18
19	Laundry	3,544	3,552	57,494	16.19	19
20	Administrator	2,122	2,131	106,445	49.95	20
21	Assistant Administrator	2,439	2,439	82,208	33.71	21
22	Other Administrative	1,640	1,667	48,680	29.20	22
23	Office Manager	2,287	2,322	60,634	26.11	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)	125,339	126,765	\$ 3,319,032 *	\$ 26.18	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		\$ 12,603	1, 3	35
36	Medical Director		37,200	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,041	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		2,192	11, 3	44
45	Social Service Consultant		2,145	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 62,181		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	806	\$ 66,396	10, 3	50
51	Licensed Practical Nurses	8,044	487,862	10, 3	51
52	Certified Nurse Assistants/Aides	3,023	116,959	10, 3	52
53	TOTAL (lines 50 - 52)	11,873	\$ 671,217		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

Richland Nursing Rehab

0056671

Report Period Beginning: 01/01/2025

Page 21

Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Bryce Kapper

Administrator

0

\$ 32,917

Deborah Wente

Administrator

0

73,528

Anne Zuber

Asst Administrator

0

82,208

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

(List each licensed administrator separately.)

\$ 188,653

B. Administrative - Other

Description

Amount

Bridgemark Healthcare, LLC - Management Fees

\$ 373,300

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

(Attach a copy of any management service agreement)

\$ 373,300

C. Professional Services

Vendor/Payee

Type

Amount

C.J. Schlosser & Company, LLC

Accounting Fees

\$ 3,825

Polsinelli PC

Legal Fees - Regulatory Complia

19,249

Personnel Planners

Unemployment Consulting

1,733

Paylocity

Payroll Processing

24,689

Saric Consulting

Medicaid Consulting

7,150

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

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

\$ 56,646

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 55,012

Unemployment Compensation Insurance

22,293

FICA Taxes

252,209

Employee Health Insurance

46,970

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Benefits

3,345

401k Match

12,597

Related Party Allocation - Bridgemark

24,705

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

\$ 417,131

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

12,865

Health Care Worker Background Check

2,388

(Indicate # of checks performed)

Patient Background Checks

Association Dues (total from pg 22, #4)

13,314

Dues & Subscriptions

6,588

Miscellaneous Licenses & Fees

4,389

Advertising

17,880

Related Party Allocation - Bridgemark

1,561

Less: Public Relations Expense

()

PAC and Lobbying payments

(4,275)

All non-allowable advertising

(17,880)

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

\$ 38,820

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

251

Seminar Expense

Online Learning - Relias

8,711

Related Party Allocation - Bridgemark

3,557

Entertainment Expense

()

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

TOTAL

\$ 12,519

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	
HEALTH CARE COUNCIL OF IL (HCCI)	9,039
	9,039 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	126
HEALTH CARE COUNCIL OF IL (HCCI)	4,149
	4,275 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	126
HEALTH CARE COUNCIL OF IL (HCCI)	13,188
	13,314 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 34,341 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.

\$ 598,376

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?

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

No
- (13)

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

Firm Name: N/A

No
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes Attach invoices and a summary of services for all architect and appraisal fees.