		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048827

Facility Name: Helia Healthcare Belleville

Address: 40 North 64th Street (Number) Belleville (City) 62223 (Zip Code)

County: St Clair

Telephone Number: (618) 397-8400 Fax # (618) 397-8470

HFS ID Number:

Date of Initial License for Current Owners: 12/01/07

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Cindy A. Teftteller 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 01/01/2020 to 12/31/2020 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 Preparatoin Report (Date)
	(Print Name and Title)	Cindy A. Tefteller Partner
	(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
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	122	Skilled (SNF)	122	44,652	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	122	TOTALS	122	44,652	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,198	420	2,474	20,092	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,198	420	2,474	20,092	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.00%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 1,972

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number: Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	163,216	10,434	12,931	186,581		186,581		186,581			1
2	Food Purchase		122,913		122,913		122,913	(13)	122,900			2
3	Housekeeping	122,319	30,297	390	153,006		153,006		153,006			3
4	Laundry	41,828	25,600		67,428		67,428		67,428			4
5	Heat and Other Utilities			154,079	154,079		154,079	(18,139)	135,940			5
6	Maintenance	69,084	18,673	61,791	149,548		149,548		149,548			6
7	Other (specify):*											7
8	**TOTAL General Services**	396,447	207,917	229,191	833,555		833,555	(18,152)	815,403			8
	B. Health Care and Programs											
9	Medical Director			36,675	36,675		36,675		36,675			9
10	Nursing and Medical Records	1,423,123	181,360	511,485	2,115,968		2,115,968	20,064	2,136,032			10
10a	Therapy	683,032	121,612		804,644		804,644		804,644			10a
11	Activities	31,005	2,348	2,892	36,245		36,245	(450)	35,795			11
12	Social Services	49,197	96	2,577	51,870		51,870		51,870			12
13	CNA Training											13
14	Program Transportation			2,890	2,890		2,890		2,890			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,186,357	305,416	556,519	3,048,292		3,048,292	19,614	3,067,906			16
	C. General Administration											
17	Administrative	103,579		363,600	467,179		467,179	(343,448)	123,731			17
18	Directors Fees											18
19	Professional Services			72,116	72,116		72,116	6,543	78,659			19
20	Dues, Fees, Subscriptions & Promotions			47,056	47,056		47,056	(22,347)	24,709			20
21	Clerical & General Office Expenses	121,415	32,545	92,127	246,087		246,087	101,848	347,935			21
22	Employee Benefits & Payroll Taxes			299,051	299,051		299,051	11,701	310,752			22
23	Inservice Training & Education											23
24	Travel and Seminar			439	439		439	1,764	2,203			24
25	Other Admin. Staff Transportation			2,711	2,711		2,711	2,519	5,230			25
26	Insurance-Prop.Liab.Malpractice			306,580	306,580		306,580	16,966	323,546			26
27	Other (specify):*											27
28	**TOTAL General Administration**	224,994	32,545	1,183,680	1,441,219		1,441,219	(224,454)	1,216,765			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,807,798	545,878	1,969,390	5,323,066		5,323,066	(222,992)	5,100,074			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,118	81,118		81,118	2,864	83,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,825	10,825		10,825	(5,622)	5,203			32
33	Real Estate Taxes			66,000	66,000		66,000	31	66,031			33
34	Rent-Facility & Grounds			788,472	788,472		788,472	5,297	793,769			34
35	Rent-Equipment & Vehicles			101,025	101,025		101,025	787	101,812			35
36	Other (specify):*											36
37	TOTAL Ownership			1,047,440	1,047,440		1,047,440	3,357	1,050,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		332,416	366,086	698,502		698,502		698,502			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,520	181,520		181,520		181,520			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		332,416	547,606	880,022		880,022		880,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,807,798	878,294	3,564,436	7,250,528		7,250,528	(219,635)	7,030,893			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

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(450)	11		4
5	Telephone, TV & Radio in Resident Rooms	(18,539)	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	(5,622)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	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	(550)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,087)	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	(17,204)	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	(7,953)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (52,418)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(167,217)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (167,217)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (219,635)		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

STATE OF ILLINOIS

Helia Healthcare Belleville

ID# 0048827

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Elminate Gifts & Flowers	$ (2,661)	20	1
2	To Elminate Lobbying/PAC Dues	(2,999)	20	2
3	To Offset Medical Record Inome	(2,293)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,953)		49

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcar	St. Ann, MO	Management Co.
		Hillside Rehab & Care Center	Yorkville, IL	Helia Healthcare Servi	Benton, IL	Laundry Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Ann, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Palladian Management	O'Fallon, IL	Management Co.
		Helia Southbelt Healthcare	Belleville, IL	Palladian Mt. Vernon A	Mt. Vernon, IL	Assisted Living
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Palladian Taylorville A	Taylorville, IL	Assisted Living
		Helia Healthcare of Hillsboro	Hillsboro, IL			

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. [X] 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	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 400	$ 400	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	22,357	22,357	2
3	V	17	Management Fees	363,600	Bridgemark Healthcare, LLC	100.00%	20,152	(343,448)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	6,543	6,543	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,067	1,067	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	103,935	103,935	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	11,701	11,701	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	1,764	1,764	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	2,519	2,519	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	16,966	16,966	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,864	2,864	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	31	31	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	5,297	5,297	13
14	Total			$ 363,600			$ 195,596	$ * (168,004)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 787	$ 787	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 787	$ * 787	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Effingham	Effingham, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				7
8			Helia Richland Healthcare, LLC	Olney, IL				8
9			Helia Healthcare of Newton, LLC	Newton, IL				9
10			Palladian Aviston SNF, LLC	Aviston, IL				10
11			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				11
12			Palladian Taylorville SNF, LLC	Taylorville, IL				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

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	386,276	2.48	4.96	Distribution	$ 20,152	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	$ 20,152		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 [X] 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 172
City / State / Zip Code: Saint Ann, MO 63074
Phone Number: (314) 431-0511
Fax Number: (314) 754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	405,225	17	$ 8,060	$	20,092	$ 400	1
2	10	Nursing & Medical Records	Resident Days	405,225	17	450,909	450,909	20,092	22,357	2
3	17	Owners Compensation	Resident Days	405,225	17	406,428		20,092	20,152	3
4	19	Professoinal Fees	Resident Days	405,225	17	131,963		20,092	6,543	4
5	20	Dues, Subscriptions	Resident Days	405,225	17	21,510		20,092	1,067	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	20,092	82,438	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		20,092	21,497	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	405,225	17	235,995		20,092	11,701	8
9	24	Seminars	Resident Days	405,225	17	35,584		20,092	1,764	9
10	25	Admin Staff Travel	Resident Days	405,225	17	50,795		20,092	2,519	10
11	26	Insurance	Resident Days	405,225	17	342,172		20,092	16,966	11
12	30	Depreciation	Resident Days	405,225	17	57,762		20,092	2,864	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		20,092	31	13
14	34	Building Rent	Resident Days	405,225	17	97,672		20,092	4,843	14
15	34	Rental - Storage Unit	Resident Days	405,225	17	9,163		20,092	454	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		20,092	787	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,960,735	$ 2,113,564		$ 196,383	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.	8,123	6
7	Omnicare		X	Vendor Note						7.5000	43	7
8	Medline		X	Vendor Note		11/15/19				8.0000	2,659	8
9	TOTAL Facility Related						$	$			$ 10,825	9
	B. Non-Facility Related*											
10	Interest Income Offset										(5,622)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,622)	14
15	TOTALS (line 9+line14)						$	$			$ 5,203	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.)

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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.)	$	66,000	2
3. Under or (over) accrual (line 2 minus line 1).	$	66,000	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ______ **For** ____ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	66,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	72,713	8
	2016	64,249	9
	2017	65,539	10
	2018	64,897	11
	2019	66,063	12

66,000 Line 7 Real Estate Tax portion of Lease Payment
31 Bridgemark Allocation
66,031 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare Belleville COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048827

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-12.0-213-024	Penns 2nd Bub Lob/Sec-61 PT LTS	$ 66,063.30	$ 66,063.30
2.		61, 62 &64	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,063.30	$ 66,063.30

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 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: ______ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: ______ 2. Number of Years Over Which it is Being Amortized: ______

3. Current Period Amortization: ______ 4. Dates Incurred: ______

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plasterers			2007	6,731	337	20	337		4,712	9
10	Air Units			2007	1,215		10			1,215	10
11	Supplies for Sign			2007	1,060		10			1,060	11
12	Vanities			2008	810		10			810	12
13	Windows			2008	1,065	53	20	53		657	13
14	Sprinklers			2008	7,898	527	15	527		6,450	14
15	Asphalt for Rear of Building			2008	2,085		8			2,085	15
16	New Nurse's Station & Renovation of front entrance & hallways			2009	35,615	2,374	15	2,374		27,024	16
17	Asphalt for Front of Building			2009	1,295		8			1,295	17
18	Cabinets			2009	3,965	264	15	264		2,996	18
19	Carpet			2009	9,553		5			9,553	19
20	14 Doors			2009	4,382	292	15	292		3,262	20
21	Wing Remodel - Carpet, hand rails, paint, nurses station, plumbing, door			2010	56,248	2,812	20	2,812		28,827	21
22	Rooftop Heater & Compressor			2010	6,782	452	15	452		4,860	22
23	Cabinets for Utility			2010	1,023	68	15	68		716	23
24	Tile & Carpet			2010	4,793		5			4,793	24
25	Countertops			2010	1,352	90	10	90		939	25
26	Facility Signage			2010	3,292	274	10	274		3,292	26
27	A/C Units			2011	6,876	688	10	688		6,819	27
28	Shower Room - flooring, electric, shower heads, fixtures, paint			2011	9,427	629	15	629		5,708	28
29	A/C Units			2011	6,675		5			6,675	29
30	New Amp Meter			2012	595	60	10	60		516	30
31	Replace security system keypad			2012	717	72	10	72		615	31
32	HVAC System			2012	6,755	450	15	450		3,828	32
33	Entrance Door			2012	2,397	160	15	160		1,305	33
34	PTAC Units			2012	2,169	217	10	217		1,808	34
35	Water Heater Booster			2012	1,448	145	10	145		1,195	35
36	Frigidaire PTAC Units			2012	2,895		5			2,895	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 Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Radiator for Generator	2013	$ 3,846	$ 385	10	$ 385	$	$ 2,660	37
38	Data Cabling & Wiring	2014	2,812	281	10	281		1,922	38
39	Hand Rail Lumber	2014	3,486	232	15	232		1,549	39
40	Nurses Station POC	2014	698		5			698	40
41	Room Signs	2014	1,694		5			1,694	41
42	Frigidaire Coor/Heater	2014	739		5			739	42
43	Alarm System	2014	2,350	235	10	235		1,488	43
44	3 Commodes	2014	828	83	10	83		517	44
45	3 New AC Untis	2014	1,901		5			1,901	45
46	5 PTAC Units	2015	3,000	150	5	150		3,000	46
47	Ventilatro Monitoring system and cameras	2015	6,645	997	15	997		6,645	47
48	Tile and Backling for front sitting area & therapy room	2015	8,279	828	10	828		4,209	48
49	Water Heater	2015	3,910	391	10	391		1,955	49
50	Dining Room Paint	2018	5,610	561	10	561		1,402	50
51	100 Gallon Water Heater	2018	7,531	753	10	753		1,632	51
52	Cabinets, Flooring, Sink, Counters in Therapy room	2019	5,585	372	15	372		652	52
53	Hot Water Heater	2019	7,531	753	15	753		1,318	53
54	Rework Plumbing System per IDPH	2019	11,224	561	10	561		795	54
55	Flooring 200 Hall & Dining Room	2019	8,294	829	10	829		1,106	55
56	New Windows throughout the facility	2019	60,136	3,007	20	3,007		3,633	56
57	Back Flow Preventer at ain water supply	2019	14,503	725	20	725		906	57
58	Roofing Membrane	2019	15,000	1,500	10	1,500		1,625	58
59	200 Hall Raskin Alpine Whisper LVP - Modern	2020	1,820	167	10	167		167	59
60	Hot Water Heater - Axis Plumbing	2020	9,485		10				60
61									61
62									62
63									63
64									64
65									65
66	Related Party Allocation - Bridgemark Healthacer, LLC								66
67	New Office Build Out	2011	6,734		20	357	357	3,371	67
68	Conference Rm Chair Rail & Paint	2012	76		20			76	68
69	AC Unit in Server Room	2018	522		20	26	26	65	69
70	TOTAL (lines 4 thru 69)		$ 383,357	$ 22,774		$ 23,157	$ 383	$ 181,635	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 457,014	$ 51,097	$ 53,247	$ 2,150		$ 301,378	71
72	Current Year Purchases	18,765	2,710	3,041	331		3,041	72
73	Fully Depreciated Assets	13,221					13,221	73
74								74
75	TOTALS	$ 489,000	$ 53,807	$ 56,288	$ 2,481		$ 317,640	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Ford E-450	2010	$ 4,000	$	$	$	4	$ 4,000	76
77	Facility	Van	2016	20,000	2,083	2,083		4	20,000	77
78	Facility	2007 Chevy Uplander Minivan w/	2020	11,780	2,454	2,454		4	2,454	78
79										79
80	TOTALS			$ 35,780	$ 4,537	$ 4,537	$		$ 26,454	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 908,137	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 81,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,982	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,864	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 525,729	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.

SEE ACCOUNTANTS' PREPARATION REPORT

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Belleville 64th 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. [X] 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:		122		$ 786,138			3
4	Additions							4
5	Related Party Allocations - Bridgemark Healthcare				5,297			5
6	Storage Rental				2,334			6
7	TOTAL		122		$ 793,769 **			7

10. Effective dates of current rental agreement:
    Beginning 5/7/18
    Ending 4/30/38

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

9. Option to Buy: [ ] YES [X] NO Terms: ______ *

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 101,812 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Belleville
Attachment to Schedule XII B
Equipment Rentals
12/31/2020

	Description	
16A	Nursing Equipment Rental	30,551
16B	Respiratory Equipment	65,754
16C	Copier Lease	4,720
16D	Related Party Allocation - Bridgemark Healthcare	787
		101,812

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
[X] 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
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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	

(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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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	10a, 2	hrs				46		46	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				217,815		217,815	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxygen, Enter	39, 2					114,601		114,601	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3 & 10a, 2				366,086	121,566		487,652	13
14	TOTAL			$		$ 366,086	$ 454,028		$ 820,114	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

Facility Name & ID Number Helia Healthcare Belleville # 0048827 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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	$ 5,552	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (20,000))	916,821		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	553		7
8	Accounts Receivable (owners or related parties)	5,611,087		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,534,013	$	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	363,458		15
16	Equipment, at Historical Cost	526,580		16
17	Accumulated Depreciation (book methods)	(512,562)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 377,476	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,911,489	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 406,399	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,556		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,548		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	10,466		36
37	Deferred CARES Funds	400,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 976,969	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	291,142		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 291,142	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,268,111	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,643,378	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,911,489	$	48

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*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,330,467	1
2	Restatements (describe):		2
3	2019 Adjustments	(175)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,330,292	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	313,086	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)**	$ 313,086	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)**	$ 5,643,378	24 *

*** This must agree with page 17, line 47.**

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,071,110	1
2	Discounts and Allowances for all Levels	(284,557)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,786,553	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	188,534	6
7	Oxygen	14,351	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 202,885	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***	5,622	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,622	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Medical Records/Miscellaneous	20,004	28
28a	CARES Funds	548,550	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 568,554	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,563,614	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	833,555	31
32	Health Care	3,048,292	32
33	General Administration	1,441,219	33
	B. Capital Expense		
34	Ownership	1,047,440	34
	C. Ancillary Expense		
35	Special Cost Centers	698,502	35
36	Provider Participation Fee	181,520	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,250,528	40
41	**Income before Income Taxes (line 30 minus line 40)****	313,086	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 313,086	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,336,159	44
45	Private Pay - Net Inpatient Revenue	111,337	45
46	Medicare - Net Inpatient Revenue	1,125,651	46
47	Other-(specify) Insurance	134,430	47
48	Other-(specify) Hospice	78,976	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,786,553	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Filed Yet If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,168	2,296	$ 97,132	$ 42.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,609	8,283	284,374	34.33	3
4	Licensed Practical Nurses	16,820	18,206	546,034	29.99	4
5	CNAs & Orderlies	25,267	27,109	443,517	16.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,707	1,858	31,005	16.69	10
11	Social Service Workers	2,047	2,135	49,197	23.04	11
12	Dietician					12
13	Food Service Supervisor	2,467	2,854	51,985	18.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,956	8,574	111,231	12.97	15
16	Dishwashers					16
17	Maintenance Workers	1,675	1,913	69,084	36.11	17
18	Housekeepers	8,137	8,885	122,319	13.77	18
19	Laundry	3,457	3,739	41,828	11.19	19
20	Administrator	1,768	1,998	103,579	51.84	20
21	Assistant Administrator					21
22	Other Administrative	1,424	1,779	46,215	25.98	22
23	Office Manager	2,118	2,396	75,200	31.39	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,012	2,204	52,066	23.62	31
32	Other Health C: Respiratory Thera	21,643	23,725	683,032	28.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,275	117,954	$ 2,807,798 *	$ 23.80	34

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

** See instructions.

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		$ 12,931	1, 3	35
36	Medical Director		36,675	9, 3	36
37	Medical Records Consultant		6,474	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,224	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		2,467	11, 3	44
45	Social Service Consultant		2,577	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 66,348		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	13	$ 933	10, 3	50
51	Licensed Practical Nurses	837	44,672	10, 3	51
52	Certified Nurse Assistants/Aides	13,131	420,043	10, 3	52
53	TOTAL (lines 50 - 52)	13,981	$ 465,648		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Latasha Hamilton	Administrator	0	$ 103,579
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 103,579

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 363,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 363,600

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 1,916
Much Shelist	Legal Fees	3,371
Stein Law	Legal Services	1,020
Hamlin & Burton Liability Managem	Legal Fees	20,279
O'Halloran, Kosoff, Geitner & Cook,	Legal Fees	10,237
US Bank Equip		3,225
C.J. Schlosser & Company, LLC	Accounting Services	4,000
Sandberg Phoenix & Von Gontard P(	Legal Fees	951
Paycom Payroll	Payroll Processing	23,039
Pantegra	401k Admin	3,100
Nationwide Trust	401k Admin	978
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 72,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,481
Unemployment Compensation Insurance	12,415
FICA Taxes	211,903
Employee Health Insurance	35,023
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Match	8,672
Employee Benefits	557
Related Party Allocation - Bridgemark	11,701
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,752

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	6,270
Health Care Worker Background Check	1,094
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	5,211
IHCA Dues	6,370
Advertising	17,204
Miscellaneous Licenses & Fees	2,707
Related Party Allocation - Bridgemark	1,067
Less: Public Relations Expense	( )
Non-allowable advertising	(17,204)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	199
Seminar Expense	240
Related Party Allocation - Bridgemark	1,764
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,203

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 6,370**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,715** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **181,520**
This amount is to be recorded on line 42 of Schedule V.

(12) 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.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) 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**

(14) 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.

(15) 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? **Yes** Indicate the amount. $ **450**

(16) 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**

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

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

(19) 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.