		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: 0050757

Facility Name: Helia Healthcare of Olney

Address: 410 East Mack (Number) Olney (City) 62450 (Zip Code)

County: Richland

Telephone Number: (618) 395-7421 **Fax #** (618) 395-8210

HFS ID Number:

Date of Initial License for Current Owners: 4/30/98

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. 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 01/01/2020 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 Preparation 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 of Olney # 0050757 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	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	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,957	6,076	5,271	30,304	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,957	6,076	5,271	30,304	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.17%

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 4/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 4,809

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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	184,714	20,703	10,375	215,792		215,792		215,792			1
2	Food Purchase		201,006		201,006		201,006	(200)	200,806			2
3	Housekeeping	97,771	28,520	100	126,391		126,391		126,391			3
4	Laundry	42,166	14,878	4,256	61,300		61,300		61,300			4
5	Heat and Other Utilities			117,968	117,968		117,968	(13,215)	104,753			5
6	Maintenance	41,319	21,273	46,457	109,049		109,049		109,049			6
7	Other (specify):*											7
8	TOTAL General Services	365,970	286,380	179,156	831,506		831,506	(13,415)	818,091			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,615,769	119,634	4,484	1,739,887		1,739,887	33,556	1,773,443			10
10a	Therapy		60		60		60		60			10a
11	Activities	27,008	16,139	2,633	45,780		45,780	(1,129)	44,651			11
12	Social Services	29,353	403	2,747	32,503		32,503		32,503			12
13	CNA Training											13
14	Program Transportation			10,575	10,575		10,575		10,575			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,672,130	136,236	32,439	1,840,805		1,840,805	32,427	1,873,232			16
	C. General Administration											
17	Administrative	90,303		360,500	450,803		450,803	(330,106)	120,697			17
18	Directors Fees											18
19	Professional Services			28,507	28,507		28,507	9,869	38,376			19
20	Dues, Fees, Subscriptions & Promotions			71,626	71,626		71,626	(48,282)	23,344			20
21	Clerical & General Office Expenses	59,800	17,440	143,433	220,673		220,673	154,173	374,846			21
22	Employee Benefits & Payroll Taxes			305,992	305,992		305,992	17,648	323,640			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,151	3,151		3,151	2,661	5,812			24
25	Other Admin. Staff Transportation			7,716	7,716		7,716	3,799	11,515			25
26	Insurance-Prop.Liab.Malpractice			127,577	127,577		127,577	25,589	153,166			26
27	Other (specify):*											27
28	TOTAL General Administration	150,103	17,440	1,048,502	1,216,045		1,216,045	(164,649)	1,051,396			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,188,203	440,056	1,260,097	3,888,356		3,888,356	(145,637)	3,742,719			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.

Facility Name & ID Number Helia Healthcare of Olney #0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			41,150	41,150		41,150	4,320	45,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			104,708	104,708		104,708		104,708			32
33	Real Estate Taxes			54,000	54,000		54,000	47	54,047			33
34	Rent-Facility & Grounds			616,279	616,279		616,279	7,989	624,268			34
35	Rent-Equipment & Vehicles			7,913	7,913		7,913	1,187	9,100			35
36	Other (specify):*											36
37	**TOTAL Ownership**			824,050	824,050		824,050	13,543	837,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,292	660,566	814,858		814,858		814,858			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,103	225,103		225,103		225,103			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		154,292	885,669	1,039,961		1,039,961		1,039,961			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,188,203	594,348	2,969,816	5,752,367		5,752,367	(132,094)	5,620,273			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 of Olney # 0050757 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	(1,129)	11		4
5	Telephone, TV & Radio in Resident Rooms	(13,818)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(200)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,589)	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	(36,961)	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	(13,094)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,791)		$	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)	(64,303)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (64,303)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (132,094)		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

Helia Healthcare of Olney

ID# 0050757

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	$ (9,529)	20	1
2	To Eliminate PAC Dues & Lobbying Expense	(2,901)	20	2
3	To Offset Medical Records Income	(164)	10	3
4	To Eliminate Chamber of Commerce Fees	(500)	20	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**	(13,094)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(200)	0	0	0	0	0	0	0	0	0	0	(200)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(13,818)	603	0	0	0	0	0	0	0	0	0	(13,215)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,018)	603	0	0	0	0	0	0	0	0	0	(13,415)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(164)	33,720	0	0	0	0	0	0	0	0	0	33,556	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,129)	0	0	0	0	0	0	0	0	0	0	(1,129)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,293)	33,720	0	0	0	0	0	0	0	0	0	32,427	16
	C. General Administration													
17	Administrative	0	(330,106)	0	0	0	0	0	0	0	0	0	(330,106)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,869	0	0	0	0	0	0	0	0	0	9,869	19
20	Fees, Subscriptions & Promotions	(49,891)	1,609	0	0	0	0	0	0	0	0	0	(48,282)	20
21	Clerical & General Office Expenses	(2,589)	156,762	0	0	0	0	0	0	0	0	0	154,173	21
22	Employee Benefits & Payroll Taxes	0	17,648	0	0	0	0	0	0	0	0	0	17,648	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,661	0	0	0	0	0	0	0	0	0	2,661	24
25	Other Admin. Staff Transportation	0	3,799	0	0	0	0	0	0	0	0	0	3,799	25
26	Insurance-Prop.Liab.Malpractice	0	25,589	0	0	0	0	0	0	0	0	0	25,589	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(52,480)	(112,169)	0	0	0	0	0	0	0	0	0	(164,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(67,791)	(77,846)	0	0	0	0	0	0	0	0	0	(145,637)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Olney **#** 0050757 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	4,320	0	0	0	0	0	0	0	0	0	4,320	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	47	0	0	0	0	0	0	0	0	0	47	33
34	Rent-Facility & Grounds	0	7,989	0	0	0	0	0	0	0	0	0	7,989	34
35	Rent-Equipment & Vehicles	0	0	1,187	0	0	0	0	0	0	0	0	1,187	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	12,356	1,187	0	0	0	0	0	0	0	0	13,543	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,791)	(65,490)	1,187	0	0	0	0	0	0	0	0	(132,094)	45

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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.
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Helia Healthcare Serv.	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Ann, MO	Human Resources
		Helia Healthcare of Belleville	Belleville, IL	Palladian Taylorville,	Taylorville, IL	Assissted Living
		Helia Southbelt Healthcare	Belleville, IL	Palladian Managemen	O'Fallon, IL	Management Co
				Palladian Mt. Vernon	Mt. Vernon, IL	Assissted 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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 603	$ 603	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	33,720	33,720	2
3	V	17	Management Fees	360,500	Bridgemark Healthcare, LLC	100.00%	30,394	(330,106)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	9,869	9,869	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,609	1,609	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	156,762	156,762	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	17,648	17,648	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,661	2,661	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,799	3,799	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	25,589	25,589	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,320	4,320	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	47	47	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	7,989	7,989	13
14	Total			$ 360,500			$ 295,010	$ * (65,490)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 1,187	$ 1,187	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			$			$ 1,187	$ * 1,187	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6			Helia Healthcare of Effingham	Effingham, IL				6
7			Helia Healthcare of Salem	Salem, IL				7
8			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				8
9			Helia Richland Healthcare, LLC	Olney, IL				9
10			Helia Healthcare of Newton, LLC	Newton, IL				10
11			Palladian Taylorville SNF, LLC	Taylorville, IL				11
12			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				12
13			Palladian Aviston SNF, LLC	Aviston, IL				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 of Olney # 0050757 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	376,034	3.74	7.48	Distribution	$ 30,394	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	$ 30,394		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 of Olney # 0050757 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 712
City / State / Zip Code: St. 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	$	30,304	$ 603	1
2	10	Nursing & Medical Supplies	Resident Days	405,225	17	450,909		30,304	33,720	2
3	17	Owner's Compensation	Resident Days	405,225	17	406,428	406,428	30,304	30,394	3
4	19	Professional Fees	Resident Days	405,225	17	131,963		30,304	9,869	4
5	20	Dues, Subscriptions	Resident Days	405,225	17	21,510		30,304	1,609	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	30,304	124,339	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		30,304	32,423	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	405,225	17	235,995		30,304	17,648	8
9	24	Seminars	Resident Days	405,225	17	35,584		30,304	2,661	9
10	25	Admin Staff Travel	Resident Days	405,225	17	50,795		30,304	3,799	10
11	26	Insurance	Resident Days	405,225	17	342,172		30,304	25,589	11
12	30	Depreciation	Resident Days	405,225	17	57,762		30,304	4,320	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		30,304	47	13
14	34	Building Rent	Resident Days	405,225	17	97,672		30,304	7,304	14
15	34	Rental - Storage Unit	Resident Days	405,225	17	9,163		30,304	685	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		30,304	1,187	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,960,735	$ 2,069,083		$ 296,197	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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				Variable	104,442	6
7	Medline		X	Vendor Note		11/15/19				8.0000	517	7
8												8
9	TOTAL Facility Related						$	$			$ 104,959	9
	B. Non-Facility Related*											
10	Interest Income Offset										(251)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (251)	14
15	TOTALS (line 9+line14)						$	$			$ 104,708	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 of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)		$ 54,000	2
3. Under or (over) accrual (line 2 minus line 1).		$ 54,000	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.		$ 54,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	69,295	8
	2016	50,394	9
	2017	52,264	10
	2018	53,113	11
	2019	45,302	12

54,000 Line 7, Real Estate portion of Lease payment
47 Bridgemark Healthcare Allocation
54,047 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 of Olney COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0050757

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 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.	06-27-450-002	Plat/Block/Lot PT SW SE SE	$ 45,302.18	$ 45,302.18
2.		Unplatted 55	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,302.18	$ 45,302.18

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.

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,034 B. General Construction Type: Exterior Brick Frame Steel/Concrete 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 of Olney # 0050757 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	20,000 Watt Generator			2010	8,067		5			8,067	9
10	Upgrade Existing Fire Alarm System			2010	16,191	270	10	270		16,191	10
11	Fire Alarm Panel & Fire Doors			2011	20,209	1,954	10	1,954		18,677	11
12	A/C System Improvements & New A/C Units			2011	9,134	159	15	159		8,221	12
13	Signs			2012	7,427	743	10	743		6,065	13
14	AC Unit Replacement			2013	5,592	559	10	559		4,381	14
15	Toilets, Tubs, Lavatories, BR Fixtures, ARCH Unit			2013	5,259	263	20	263		2,104	15
16	Kitchen Cabinets, Countertops - ARCH Unit			2013	5,523	368	15	368		2,946	16
17	Door ARCH Unit			2013	10,320	688	15	688		5,504	17
18	Call System ARCH Unit			2013	1,026	103	10	103		820	18
19	Flooring ARCH Unit			2013	10,671		5			10,671	19
20	Curtains, Drapes, Blinds - ARCH Unit			2013	2,578		5			2,578	20
21	Pendent - Sprinklers			2013	1,290	86	15	86		688	21
22	GE Door Alarm Keypad - ARCH Unit			2013	1,074	107	10	107		859	22
23	Dining/Bathroom Flooring - ARCH Unit			2013	4,255	425	10	425		3,404	23
24	HTG & AC for Shower Room - ARHC Unit			2013	682		10			682	24
25	Fireplace			2013	1,499	150	5	150		1,174	25
26	Tear out old walls & replace - ARCH Unit			2013	157,405	7,870	10	7,870		62,962	26
27	4 Frigidaire Heat/Cold Units			2014	2,503	250	10	250		1,690	27
28	Replace Water Heater			2014	1,436	144	10	144		898	28
29	Schrey System			2014	1,792	179	10	179		1,120	29
30	CTS Ran Phone & Data Cable			2014	878	88	10	88		549	30
31	Redo all Kitchen Plumbing			2014	7,222	722	10	722		4,634	31
32	Frigidaire Heat/Cool Units			2014	1,259		5			1,259	32
33	Whisper Grove Hall - Prep/Paint/Floor			2015	8,331	833	10	833		4,443	33
34	Read's Inc. - AC/Heat Unit			2015	5,806	97	5	97		5,806	34
35	Hardwood Flooring & Paint - A Hall			2016	3,581	358	10	358		1,462	35
36	Replacement of Facility Roof - John Bcal			2019	81,234	4,062	20	4,062		8,123	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 of Olney # 0050757 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	Walk in Cooler:	2019	$ 4,483	$ 299	15	$ 299	$	$ 448	37
38	6'2 X 7' Double Faced Sign	2019	8,585	1,226	7	1,226		1,226	38
39	Frigidaire PTAC 9000 btu heat/cool Indoff	2020	1,413	118	10	118		118	39
40	HD Foam Directional Signs - Roth Signs	2020	646	65	5	65		65	40
41	LT900 Compressor - Tri-State Fire Port	2020	2,544	88	12	88		88	41
42									42
43									43
44									44
45									45
46	Related Party Allocation - Bridgemark Healthcare, LLC								46
47	New Office Build Out	2011	10,157		20	538	538	5,084	47
48	Conference Rm Chair Rail & Paint	2012	115		5			115	48
49	AC Unit in Server Room	2018	788		20	39	39	98	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)		$ 410,975	$ 22,274		$ 22,851	$ 577	$ 193,220	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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	$ 145,383	$ 14,008	$ 17,252	$ 3,244	3-15 Yrs	$ 78,044	71
72	Current Year Purchases	25,934	4,868	5,367	499	3-15 Yrs	5,367	72
73	Fully Depreciated Assets	27,950					27,950	73
74								74
75	TOTALS	$ 199,267	$ 18,876	$ 22,619	$ 3,743		$ 111,361	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	$ 3,407	$	$	$	4	$ 3,407	76
77										77
78										78
79										79
80	TOTALS			$ 3,407	$	$	$		$ 3,407	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)	$ 613,649	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,470	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,320	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 307,988	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 NA	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Olney 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:		118		$ 613,225			3
4	Additions							4
5	Storage Rental				3,054			5
6	Related Party Allocation				7,989			6
7	TOTAL		118		$ 624,268 **			7

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: *

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	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,100 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 Olney
Attachment to Schedule XII B
Equipment Rentals
12/31/2020

	Description	
16A	Nursing Equipment	7,643
16B	Copier Lease	270
16C	Related Party Allocation - Bridgemark Healthcare	1,187
		9,100

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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				60		60	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				134,714		134,714	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					19,578		19,578	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				660,566			660,566	13
14	TOTAL			$		$ 660,566	$ 154,352		$ 814,918	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

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Olney # 0050757 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	$ 2,924	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (126,000))	1,076,375		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,454		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,082,753	$	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	393,163		15
16	Equipment, at Historical Cost	191,291		16
17	Accumulated Depreciation (book methods)	(291,856)		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)**	$ 292,598	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,375,351	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 244,179	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,980		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,478		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	13,608		36
37	Deferred CARES Funds	801,377		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,211,622	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	567,129		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Parties	3,373,867		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,940,996	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,152,618	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,777,267)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,375,351	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,135,577)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,135,577)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,358,310	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)**	$ 1,358,310	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,777,267)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 6,989,813	1
2	Discounts and Allowances for all Levels	(244,548)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,745,265	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	231,702	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 231,702	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***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	3,710	28
28a	HHS Stimulus	130,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 133,710	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,110,677	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	831,506	31
32	Health Care	1,840,805	32
33	General Administration	1,216,045	33
	B. Capital Expense		
34	Ownership	824,050	34
	C. Ancillary Expense		
35	Special Cost Centers	814,858	35
36	Provider Participation Fee	225,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,752,367	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,358,310	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,358,310	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,167,597	44
45	Private Pay - Net Inpatient Revenue	916,268	45
46	Medicare - Net Inpatient Revenue	2,494,995	46
47	Other-(specify) Hospice	37,108	47
48	Other-(specify) Insurance	129,297	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,745,265	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,113	2,222	$ 83,512	$ 37.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,793	12,686	352,117	27.76	3
4	Licensed Practical Nurses	13,576	14,700	365,380	24.86	4
5	CNAs & Orderlies	57,809	61,459	801,294	13.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,051	2,111	27,008	12.79	10
11	Social Service Workers	1,599	1,779	29,353	16.50	11
12	Dietician					12
13	Food Service Supervisor	1,681	1,927	30,958	16.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,190	13,268	153,756	11.59	15
16	Dishwashers					16
17	Maintenance Workers	1,691	1,974	41,319	20.93	17
18	Housekeepers	8,292	8,520	97,771	11.48	18
19	Laundry	2,904	3,221	42,166	13.09	19
20	Administrator	1,910	2,159	90,303	41.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,893	2,119	45,180	21.32	23
24	Clerical	733	831	14,620	17.59	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	893	932	13,466	14.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,128	129,908	$ 2,188,203 *	$ 16.84	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 10,375	1, 3	35
36	Medical Director		12,000	9, 3	36
37	Medical Records Consultant		1,992	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,492	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		2,633	11, 3	44
45	Social Service Consultant		2,747	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,239		49

C. CONTRACT NURSES

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

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Brashear	Administrator	0	$ 90,303
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,303

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 360,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 360,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 1,916
Hamlin & Burton Liability Mgmt	Legal Fees	1,307
C.J. Schlosser & Company	Accounting Services	4,000
Nationwide Trust	401k Plan Administrative Fees	978
Pantegra	401k Plan Administrative Fees	3,100
Paycom Payroll, LLC	Payroll Processing	17,206
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 28,507

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,255
Unemployment Compensation Insurance	14,392
FICA Taxes	162,973
Employee Health Insurance	56,017
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Match	5,883
Other Employee Benefits	3,472
Related Party Allocation - Bridgemark	17,648
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,640

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	6,030
Health Care Worker Background Check	2,870
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	2,536
Advertising	36,961
Miscellaneous Licenses & Fees	2,148
IHCA Dues	6,161
Related Party Allocation - Bridgemark	1,609
Less: Public Relations Expense	( )
Non-allowable advertising	(36,961)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,344

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	450
Seminar Expense	2,701
Related Party Allocation - Bridgemark	2,661
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,812

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Olney # 0050757 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 $6,161**

(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. $ **9,816** 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. $ **225,103**
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. $ **1,129**

(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.