



Facility Name & ID Number Helia Healthcare of Champaign

# 0048181 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>118</u>	Skilled (SNF)	<u>118</u>	<u>43,070</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>27,159</u>	<u>1,732</u>	<u>3,754</u>	<u>32,645</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,159</u>	<u>1,732</u>	<u>3,754</u>	<u>32,645</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.80%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 05/01/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 118 and days of care provided 2,866

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	178,973	18,346	10,445	207,764		207,764		207,764		1
2	Food Purchase		180,747		180,747		180,747	(47)	180,700		2
3	Housekeeping	94,780	19,876		114,656		114,656		114,656		3
4	Laundry	46,597	14,014		60,611		60,611		60,611		4
5	Heat and Other Utilities			126,377	126,377		126,377	(11,274)	115,103		5
6	Maintenance	38,149	13,169	42,764	94,082		94,082		94,082		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	358,499	246,152	179,586	784,237		784,237	(11,321)	772,916		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,521,136	139,942	7,899	1,668,977		1,668,977	18,195	1,687,172		10
10a	Therapy		283	502,293	502,576		502,576		502,576		10a
11	Activities	42,910	6,549	3,653	53,112		53,112	(341)	52,771		11
12	Social Services	29,786	6	2,183	31,975		31,975		31,975		12
13	CNA Training										13
14	Program Transportation			2,624	2,624		2,624		2,624		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,593,832	146,780	539,652	2,280,264		2,280,264	17,854	2,298,118		16
	<b>C. General Administration</b>										
17	Administrative	115,131		259,181	374,312		374,312	(228,201)	146,111		17
18	Directors Fees										18
19	Professional Services			12,713	12,713		12,713	6,089	18,802		19
20	Dues, Fees, Subscriptions & Promotions			28,684	28,684		28,684	(16,895)	11,789		20
21	Clerical & General Office Expenses	43,518	13,793	62,891	120,202		120,202	140,522	260,724		21
22	Employee Benefits & Payroll Taxes			349,197	349,197		349,197	29,936	379,133		22
23	Inservice Training & Education										23
24	Travel and Seminar			393	393		393	1,462	1,855		24
25	Other Admin. Staff Transportation			8,936	8,936		8,936	11,745	20,681		25
26	Insurance-Prop.Liab.Malpractice			71,871	71,871		71,871	1,895	73,766		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	158,649	13,793	793,866	966,308		966,308	(53,447)	912,861		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,110,980	406,725	1,513,104	4,030,809		4,030,809	(46,914)	3,983,895		29

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

SEE ACCOUNTANTS' COMPILATION 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 Champaign

#0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			16,320	16,320		16,320	2,882	19,202			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			43,440	43,440		43,440	25	43,465			33
34	Rent-Facility & Grounds			186,480	186,480		186,480	8,748	195,228			34
35	Rent-Equipment & Vehicles			18,550	18,550		18,550	315	18,865			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			264,790	264,790		264,790	11,970	276,760			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,379	19,688	160,067		160,067		160,067			39
40	Barber and Beauty Shops	88			88		88		88			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	88	140,379	84,293	224,760		224,760		224,760			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,111,068	547,104	1,862,187	4,520,359		4,520,359	(34,944)	4,485,415			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(341)	11		4
5	Telephone, TV & Radio in Resident Rooms	(11,274)	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	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(9,750)	21		18
19	Entertainment	(2,265)	21		19
20	Contributions	(1,535)	21		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	(11,191)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,780)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (43,208)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	8,264	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 8,264		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (34,944)		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	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Champaign

ID# 0048181

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	TO ELIMINATE GIFTS & FLOWERS	\$ (4,079)	20	1
2	TO ELIMINATE COLLECTION FEES	(17)	21	2
3	TO ELIMINATE LOBBYING & PAC DUES	(2,684)	20	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	<b>Total</b>	(6,780)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Champaign# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(47)	0	0	0	0	0	0	0	0	0	0	(47)	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	(11,274)	0	0	0	0	0	0	0	0	0	0	(11,274)	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	<b>TOTAL General Services</b>	<b>(11,321)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,321)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	18,195	0	0	0	0	0	0	0	0	0	18,195	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(341)	0	0	0	0	0	0	0	0	0	0	(341)	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	<b>TOTAL Health Care and Programs</b>	<b>(341)</b>	<b>18,195</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17,854</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(228,201)	0	0	0	0	0	0	0	0	0	(228,201)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,089	0	0	0	0	0	0	0	0	0	6,089	19
20	Fees, Subscriptions & Promotions	(17,954)	1,059	0	0	0	0	0	0	0	0	0	(16,895)	20
21	Clerical & General Office Expenses	(13,567)	154,089	0	0	0	0	0	0	0	0	0	140,522	21
22	Employee Benefits & Payroll Taxes	0	29,936	0	0	0	0	0	0	0	0	0	29,936	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,462	0	0	0	0	0	0	0	0	0	1,462	24
25	Other Admin. Staff Transportation	0	11,745	0	0	0	0	0	0	0	0	0	11,745	25
26	Insurance-Prop.Liab.Malpractice	0	1,895	0	0	0	0	0	0	0	0	0	1,895	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(31,521)</b>	<b>(21,926)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(53,447)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(43,183)</b>	<b>(3,731)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46,914)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Champaign# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	2,882	0	0	0	0	0	0	0	0	0	2,882	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	25	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	25	0	0	0	0	0	0	0	0	0	25	33
34	Rent-Facility & Grounds	0	0	8,748	0	0	0	0	0	0	0	0	8,748	34
35	Rent-Equipment & Vehicles	0	0	315	0	0	0	0	0	0	0	0	315	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	(25)	2,932	9,063	0	0	0	0	0	0	0	0	11,970	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(43,208)	(799)	9,063	0	0	0	0	0	0	0	0	(34,944)	45



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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%	See Attached		Bridgemark Healthcare	St. Louis	Management Co.
				Helia Healthcare Services	Benton	Laundry, Maint.
				Bridgemark Employer Services	St. Louis	Human Resources
				Bridgemark Medical Supply	St. Louis	Medical Supplies

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing & Medical Records	\$	Bridgemark Healthcare, L.L.C.	100.00%	\$ 18,195	\$ 18,195	1
2	V	17 Administrative	259,181	Bridgemark Healthcare, L.L.C.	100.00%	30,980	(228,201)	2
3	V	19 Professional Services		Bridgemark Healthcare, L.L.C.	100.00%	6,089	6,089	3
4	V	20 Dues, Subscriptions, & Fees		Bridgemark Healthcare, L.L.C.	100.00%	1,059	1,059	4
5	V	21 Clerical & General Office Expenses		Bridgemark Healthcare, L.L.C.	100.00%	154,089	154,089	5
6	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, L.L.C.	100.00%	29,936	29,936	6
7	V	24 Travel & Seminars		Bridgemark Healthcare, L.L.C.	100.00%	1,462	1,462	7
8	V	25 Admin Staff Transportation		Bridgemark Healthcare, L.L.C.	100.00%	11,745	11,745	8
9	V	26 Insurance		Bridgemark Healthcare, L.L.C.	100.00%	1,895	1,895	9
10	V	30 Depreciation		Bridgemark Healthcare, L.L.C.	100.00%	2,882	2,882	10
11	V	32 Interest		Bridgemark Healthcare, L.L.C.	100.00%	25	25	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, L.L.C.	100.00%	25	25	12
13	V			Bridgemark Healthcare, L.L.C.	100.00%			13
14	Total		\$ 259,181			\$ 258,382	\$ * (799)	14

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

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.  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	34 Rent - Facility & Grounds	\$	Bridgemark Healthcare, L.L.C.	100.00%	\$ 8,748	\$	8,748	15
16	V	35 Equipment Rental		Bridgemark Healthcare, L.L.C.	100.00%	315		315	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		\$			\$ 9,063	\$ *	9,063	39

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/10 Ending: 12/31/10

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	269,020	5	10.33	Distribution	\$ 30,980	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	\$ 30,980		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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Bridgemark Healthcare, L.L.C.  
 Street Address 11970 Borman Drive, Suite 100  
 City / State / Zip Code St. Louis, MO 63146  
 Phone Number ( 314) 431-0511  
 Fax Number ( 314) 754-9176

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing & Medical Records	Resident Days	316,121	13	\$ 176,191	\$ 176,191	32,645	\$ 18,195	1
2	17	Owners Compensation	Resident Days	316,121	13	300,000		32,645	30,980	2
3	19	Professional Fees	Resident Days	316,121	13	58,959		32,645	6,089	3
4	20	Dues, Subscriptions	Resident Days	316,121	13	10,259		32,645	1,059	4
5	21	Salaries - Other	Resident Days	316,121	13	1,022,795	1,022,795	32,645	105,621	5
6	21	Clerical	Resident Days	316,121	13	469,344		32,645	48,468	6
7	22	Employee Benefits	Resident Days	316,121	13	289,889		32,645	29,936	7
8	24	Seminars	Resident Days	316,121	13	14,156		32,645	1,462	8
9	25	Admin Staff Transportation	Resident Days	316,121	13	113,730		32,645	11,745	9
10	26	Insurance	Resident Days	316,121	13	18,353		32,645	1,895	10
11	30	Depreciation	Resident Days	316,121	13	27,905		32,645	2,882	11
12	32	Interest	Resident Days	316,121	13	242		32,645	25	12
13	33	Real Estate Taxes	Resident Days	316,121	13	241		32,645	25	13
14	34	Building Rent	Resident Days	316,121	13	83,985		32,645	8,673	14
15	34	Rental - Storage Unit	Resident Days	316,121	13	723		32,645	75	15
16	35	Equipment Rental	Resident Days	316,121	13	3,055		32,645	315	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,589,827	\$ 1,198,986		\$ 267,445	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia Healthcare of Champaign

# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6	<b>Related Party Allocation - Bridgemark</b>										25	6						
7											7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$	25	9						
<b>B. Non-Facility Related*</b>																		
10	<b>Interest Income</b>										(25)	10						
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	(25)	14						
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$		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' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>3,620</b>		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.)		\$	<b>47,060</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>43,440</b>		3
4. Real Estate Tax accrual used for 2010 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>43,440</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>42,067</u>	8	<b>FOR BHF USE ONLY</b>	
	2006	<u>40,884</u>	9		
	2007	<u>41,587</u>	10		
	2008	<u>44,953</u>	11		
	2009	<u>45,101</u>	12		
<b>43,440</b> Line 7, Real Estate Taxes included in Lease Payments					
<b>25</b> Bridgemark Healthcare Allocation					
<b>43,465</b> Total Schedule V, Line 33					
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		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' COMPILATION REPORT**

**2009 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Helia Healthcare of Champaign COUNTY Champaign  
 FACILITY IDPH LICENSE NUMBER 0048181  
 CONTACT PERSON REGARDING THIS REPORT Michael Parentin  
 TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>45-20-22-282-005</u>	<u>Long Term Care</u>	\$ <u>45,100.68</u>	\$ <u>45,100.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>45,100.68</u>	\$ <u>45,100.68</u>

**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 a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**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 Champaign

# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,000 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Schedule N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
	<b>Improvement Type**</b>								
9	Concrete		2006	2,907	291	10	291		1,260
10	Commercial Floor Covering		2006	5,183	518	10	518		2,159
11	2 Wall A/C Units		2006	935	187	5	187		811
12	2 Wall A/C Units		2006	952	190	5	190		825
13	2 Wall A/C Units		2006	941	188	5	188		816
14	A/C Unit		2006	519	104	5	104		450
15	Roofing - D & R Roofing		2007	20,600	2,060	10	2,060		7,897
16	Pipes		2007	8,346	417	20	417		1,321
17	Life Safety Detectors		2007	1,660	166	10	166		526
18	2 A/C Units		2007	2,527	505	5	505		1,810
19	Lighted Exit Sign		2007	2,211	221	10	221		682
20	A/C Unit - Direct Supply		2007	512	102	5	102		316
21	Roofing - D & R Roofing		2008	1,250	125	10	125		354
22	Heating & A/C Compressor		2008	5,979	598	10	598		1,445
23	Roof Top A/C		2008	6,097	610	10	610		1,321
24	2 Wall A/C Units		2008	1,093	219	5	219		583
25	Doors		2009	2,212	148	15	148		283
26	Remodel hall A, new doorsm flooring, rails & upgrade nurses station		2009	14,343	956	15	956		1,673
27	Signs		2009	1,049	210	5	210		227
28	Emergency Back-Up Lights		2009	914	91	10	91		91
29									
30	Modern Tile		2010	4,243	177	10	177		177
31	Carpet/Tile		2010	9,457	158	10	158		158
32									
33									
34									
35									
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' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign

# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 93,930	\$ 8,241		\$ 8,241	\$	\$ 25,185	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Champaign

# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 54,635	\$ 6,576	\$ 8,491	\$ 1,915	5-10	\$ 24,429	71
72	Current Year Purchases	5,357	49	486	437	5-10	486	72
73	Fully Depreciated Assets	58					58	73
74								74
75	TOTALS	\$ 60,050	\$ 6,625	\$ 8,977	\$ 2,352		\$ 24,973	75

D. Vehicle Depreciation (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	Related Party Allocation - Bridgemark			\$ 2,966	\$	\$ 530	\$ 530	5	\$ 1,670	76
77	Facility	Van w/ Wheelchair Lift	2008	5,817	1,454	1,454		4	3,635	77
78										78
79										79
80	TOTALS			\$ 8,783	\$ 1,454	\$ 1,984	\$ 530		\$ 5,305	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)	\$ 162,763	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,320	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,202	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,882	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 55,463	85

\*\*

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: First Healthcare Associates

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>118</u>		\$ <u>182,400</u>			3
4	Additions						4
5	Storage Rental			<u>4,080</u>			5
6	Bridgemark Healthcare Allocation			<u>8,748</u>			6
7	TOTAL	<u>118</u>		\$ <u>195,228</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 18,865 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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$		\$ 254,744	\$ 283		\$ 255,027	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			46,070			46,070	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			201,341			201,341	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 prescripts				90,759		90,759	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab &amp; X-Ray</u>	39, 3				19,688			19,688	12
13	Other (specify): <u>Wound Care, Oxy, Ent</u>	39, 2					49,620		49,620	13
14	TOTAL			\$		\$ 521,843	\$ 140,662		\$ 662,505	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' COMPILATION REPORT

Facility Name & ID Number **Helia Healthcare of Champaign**# **0048181**Report Period Beginning: **01/01/10**

Ending:

**12/31/10****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/10**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,834	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>122,171</u> )	620,421		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,076		7
8	Accounts Receivable (owners or related parties)	1,321,056		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,946,387	\$	10
	<b>B. Long-Term Assets</b>			
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	84,240		15
16	Equipment, at Historical Cost	62,324		16
17	Accumulated Depreciation (book methods)	(47,911)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 98,653	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,045,040	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 418,274	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,570		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,373		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Other Facilities</u>	135,981		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 670,198	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Note Payable - Lessor</u>	106,324		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 106,324	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 776,522	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,268,518	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,045,040	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>718,907</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>718,907</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>549,611</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>549,611</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,268,518</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number **Helia Healthcare of Champaign**# **0048181**Report Period Beginning: **01/01/10**Ending: **12/31/10**

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,809,378	1
2	Discounts and Allowances for all Levels	(111,416)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,697,962</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	368,040	6
7	Oxygen	2,434	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 370,474</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	341	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 341</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	637	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 637</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Recovery of Bad Debt</u>	75	28
28a	<u>Miscellaneous Income</u>	481	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 556</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,069,970</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	784,237	31
32	Health Care	2,280,264	32
33	General Administration	966,308	33
<b>B. Capital Expense</b>			
34	Ownership	264,790	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	160,155	35
36	Provider Participation Fee	64,605	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,520,359</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>549,611</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 549,611</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Helia Healthcare of Champaign**

# **0048181**

Report Period Beginning:

**01/01/10**

Ending:

**12/31/10**

**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	2,036	2,044	\$ 68,332	\$ 33.43	1
2	Assistant Director of Nursing	381	381	11,003	28.88	2
3	Registered Nurses	7,543	7,791	217,208	27.88	3
4	Licensed Practical Nurses	19,277	19,678	458,748	23.31	4
5	CNAs & Orderlies	54,568	56,781	673,396	11.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,849	4,206	61,694	14.67	8
9	Activity Director					9
10	Activity Assistants	4,001	4,057	42,910	10.58	10
11	Social Service Workers	1,670	1,812	29,786	16.44	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,080	44,153	21.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,275	13,601	134,820	9.91	15
16	Dishwashers					16
17	Maintenance Workers	2,018	2,133	38,149	17.89	17
18	Housekeepers	9,805	10,093	94,780	9.39	18
19	Laundry	4,903	4,969	46,597	9.38	19
20	Administrator	2,080	2,080	72,338	34.78	20
21	Assistant Administrator	2,024	2,080	42,793	20.57	21
22	Other Administrative					22
23	Office Manager	2,047	2,122	43,518	20.51	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	2,003	2,096	30,755	14.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beautician</u>	8	8	88	11.00	33
34	TOTAL (lines 1 - 33)	133,544	138,012	\$ 2,111,068 *	\$ 15.30	34

\* 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		\$ 10,445	1, 3	35
36	Medical Director		21,000	9, 3	36
37	Medical Records Consultant		2,249	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,293	10, 3	39
40	Physical Therapy Consultant		138	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,653	11, 3	44
45	Social Service Consultant		2,183	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,961		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		357	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 357		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Araceli Henson	Administrator	0	\$ 72,338	Workers' Compensation Insurance	\$ 90,333	IDPH License Fee	\$ 498	
Brenda Dively	Asst. Admin	0	42,793	Unemployment Compensation Insurance	49,100	Advertising: Employee Recruitment	1,168	
				FICA Taxes	161,472	Health Care Worker Background Check		
				Employee Health Insurance	43,621	(Indicate # of checks performed)		
				Employee Meals		<u>Patient Background Checks</u>	1,835	
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues &amp; Subscriptions</u>	4,750	
				<u>401(k) Match</u>	4,671	<u>Advertising</u>	11,191	
						<u>Bridgemark Healthcare Allocaiton</u>	1,059	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 115,131</b>	<u>Bridgemark Healthcare Allocation</u>	29,936	<u>Late Fees</u>	1,532	
<b>(List each licensed administrator separately.)</b>						<u>Misc. Fees &amp; Licenses</u>	947	
						<b>Less: Public Relations Expense</b>	( )	
<b>B. Administrative - Other</b>						<u>Non-allowable advertising</u>	(11,191)	
Description			Amount			<u>Yellow page advertising</u>	( )	
<u>Bridgemark Healthcare LLC - Management Fees</u>			\$ 259,181					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 259,181</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 379,133</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 11,789</b>	
<b>(Attach a copy of any management service agreement)</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>C. Professional Services</b>				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount		Amount	
<u>C.J. Schlosser &amp; Co.</u>	<u>Accounting Services</u>	\$ 4,150		<u>N/A</u>	\$		<u>Out-of-State Travel</u>	\$
<u>Much Shelist</u>	<u>Legal Fees</u>	72						
<u>Much Shelist</u>	<u>Collections (unallowable)</u>	17						
<u>Ceridian</u>	<u>Payroll Processing</u>	8,474					<u>In-State Travel</u>	
							<u>Seminar Expense</u>	393
							<u>Bridgemark Healthcare Allocation</u>	1,462
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>		<b>\$ 12,713</b>		<b>TOTAL</b>	<b>\$</b>		<u>Entertainment Expense</u>	( )
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							(agree to Sch. V, line 24, col. 8)	
							<b>TOTAL</b>	<b>\$ 1,855</b>

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												
2																									
3																									
4																									
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17																									
18																									
19																									
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign# 0048181

Report Period Beginning:

01/01/10

Ending:

12/31/10**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 \$4,396
- (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? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,358 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. \$ 64,605  
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' COMPILATION 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? No Indicate the amount. \$ N/A
- (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 of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Champaign  
Attachment to Schedule VII A  
Related Nursing Homes  
12/31/2010

Helia Healthcare of Belleville  
Helia Healthcare of Benton  
Helia Healthcare of Carbondale  
Helia Healthcare of Energy  
Helia Healthcare of Olney  
Helia Healthcare of Greenville  
Frankfort Healthcare & Rehab Center  
Helia Southbelt Healthcare  
Helia Healthcare of Zion  
Hillside Rehab & Care Center  
Helia Healthcare of Rolla

Helia Healthcare of Champaign  
Attachment to Schedule XII B  
Equipment Rentals  
12/31/2010

Description			
16A	Nursing Equipment Rental	\$	14,664
16B	Copier Lease		2,938
16C	Dietary Equipment Rental		948
16D	Related Party Allocation - Bridgemark		315
		<u>\$</u>	<u>18,865</u>