



Facility Name & ID Number Helia HC of Champaign

# 0048181 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 \_\_\_\_\_

	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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	28,973	1,134	2,868	32,975	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,973	1,134	2,868	32,975	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.35%

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 2,367

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Helia HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

**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	173,383	20,081	10,783	204,247		204,247		204,247		1
2	Food Purchase		183,000		183,000		183,000	(31)	182,969		2
3	Housekeeping	114,901	17,354	278	132,533		132,533		132,533		3
4	Laundry	14,224	10,382		24,606		24,606		24,606		4
5	Heat and Other Utilities			118,705	118,705		118,705	(9,748)	108,957		5
6	Maintenance	39,050	7,239	36,884	83,173		83,173		83,173		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	341,558	238,056	166,650	746,264		746,264	(9,779)	736,485		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,750	22,750		22,750		22,750		9
10	Nursing and Medical Records	1,392,173	100,630	8,128	1,500,931		1,500,931	10,928	1,511,859		10
10a	Therapy		687	247	934		934	(327)	607		10a
11	Activities	33,138	5,935	3,383	42,456		42,456	(1,269)	41,187		11
12	Social Services	43,587		2,978	46,565		46,565		46,565		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,468,898	107,252	37,486	1,613,636		1,613,636	9,332	1,622,968		16
	<b>C. General Administration</b>										
17	Administrative	142,037		262,400	404,437		404,437	(222,358)	182,079		17
18	Directors Fees										18
19	Professional Services			27,246	27,246		27,246	14,135	41,381		19
20	Dues, Fees, Subscriptions & Promotions			32,505	32,505		32,505	(19,525)	12,980		20
21	Clerical & General Office Expenses		9,799	46,987	56,786		56,786	211,701	268,487		21
22	Employee Benefits & Payroll Taxes			388,878	388,878		388,878	37,943	426,821		22
23	Inservice Training & Education										23
24	Travel and Seminar			522	522		522	4,152	4,674		24
25	Other Admin. Staff Transportation			6,517	6,517		6,517	7,096	13,613		25
26	Insurance-Prop.Liab.Malpractice			19,220	19,220		19,220	1,570	20,790		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	142,037	9,799	784,275	936,111		936,111	34,714	970,825		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,952,493	355,107	988,411	3,296,011		3,296,011	34,267	3,330,278		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 HC of Champaign

#0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			16,390	16,390	16,390	5,758	22,148				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,534	32,534	32,534	3,683	36,217				32
33	Real Estate Taxes			35,689	35,689	35,689	135	35,824				33
34	Rent-Facility & Grounds			174,235	174,235	174,235	12,806	187,041				34
35	Rent-Equipment & Vehicles			15,103	15,103	15,103	358	15,461				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			273,951	273,951	273,951	22,740	296,691				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,631	413,766	541,397	541,397		541,397				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			341,533	341,533	341,533		341,533				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		127,631	755,299	882,930	882,930		882,930				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,952,493	482,738	2,017,661	4,452,892	4,452,892	57,007	4,509,899				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

Facility Name & ID Number Helia HC of Champaign

# 0048181

Report Period Beginning: 1/1/12

Ending: 12/31/12

**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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,269)	11		4
5	Telephone, TV & Radio in Resident Rooms	(10,177)	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	164	30		9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds	(327)	10a		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	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	(3,696)	21		18
19	Entertainment	(3,217)	21		19
20	Contributions	(436)	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	(13,452)	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	(6,520)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (39,165)		\$	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	2	
		Amount	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)	96,172	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 96,172		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 57,007		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
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Helia HC of Champaign

ID# 0048181

Report Period Beginning: 1/1/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts & Flowers	\$ (2,927)	20	1
2	Eliminate Lobbying & PAC Dues	(1,603)	20	2
3	Out of Period IDPH license fee	(1,990)	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>		(6,520)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia HC of Champaign# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

## 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	(31)	0	0	0	0	0	0	0	0	0	0	(31)	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	(10,177)	429	0	0	0	0	0	0	0	0	0	(9,748)	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>(10,208)</b>	<b>429</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>(9,779)</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	10,928	0	0	0	0	0	0	0	0	0	10,928	10
10a	Therapy	(327)	0	0	0	0	0	0	0	0	0	0	(327)	10a
11	Activities	(1,269)	0	0	0	0	0	0	0	0	0	0	(1,269)	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>(1,596)</b>	<b>10,928</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>9,332</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(222,358)	0	0	0	0	0	0	0	0	0	(222,358)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,135	0	0	0	0	0	0	0	0	0	14,135	19
20	Fees, Subscriptions & Promotions	(19,972)	447	0	0	0	0	0	0	0	0	0	(19,525)	20
21	Clerical & General Office Expenses	(7,349)	219,050	0	0	0	0	0	0	0	0	0	211,701	21
22	Employee Benefits & Payroll Taxes	0	37,943	0	0	0	0	0	0	0	0	0	37,943	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,152	0	0	0	0	0	0	0	0	0	4,152	24
25	Other Admin. Staff Transportation	0	7,096	0	0	0	0	0	0	0	0	0	7,096	25
26	Insurance-Prop.Liab.Malpractice	0	1,570	0	0	0	0	0	0	0	0	0	1,570	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(27,321)</b>	<b>62,035</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>34,714</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(39,125)</b>	<b>73,392</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>34,267</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia HC of Champaign# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

## 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	164	5,594	0	0	0	0	0	0	0	0	0	5,758	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(204)	0	3,887	0	0	0	0	0	0	0	0	3,683	32
33	Real Estate Taxes	0	135	0	0	0	0	0	0	0	0	0	135	33
34	Rent-Facility & Grounds	0	12,806	0	0	0	0	0	0	0	0	0	12,806	34
35	Rent-Equipment & Vehicles	0	0	358	0	0	0	0	0	0	0	0	358	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(40)</b>	<b>18,535</b>	<b>4,245</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>22,740</b>	<b>37</b>
	<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>	<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>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(39,165)	91,927	4,245	0	0	0	0	0	0	0	0	57,007	45

**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 Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 429	\$	429	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	10,928		10,928	2
3	V	17 Administrative	262,400	Bridgemark Healthcare, LLC	100.00%	40,042		(222,358)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	14,135		14,135	4
5	V	20 Dues, Subscriptions, & Fees		Bridgemark Healthcare, LLC	100.00%	447		447	5
6	V	21 Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	219,050		219,050	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	37,943		37,943	7
8	V	24 Travel & Seminars		Bridgemark Healthcare, LLC	100.00%	4,152		4,152	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	7,096		7,096	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,570		1,570	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	5,594		5,594	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	135		135	12
13	V	34 Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	12,806		12,806	13
14	Total		\$ 262,400			\$ 354,327	\$ *	91,927	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	35 Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 358	\$	358	15
16	V	32 Interest		Bridgemark Healthcare, LLC	100.00%	3,887		3,887	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		\$			\$ 4,245	\$ *	4,245	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Helia Southbelt Healthcare	Belleville, IL				2
3			Hillside Rehab & Care Center	Yorkville, IL				3
4			Helia Healthcare of Rolla	Rolla, MO				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Champaign # 0048181 Report Period Beginning: 1/1/12 Ending: 12/31/12

## 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	296,583	5.95	11.90	Distribution	\$ 40,042	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	\$ 40,042		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 HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending: 12/31/12

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

Name of Related Organization Bridgemark Healthcare, LLC  
 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

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

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	5	Utilities	Resident Days	277,215	11	\$ 3,605	\$ 32,975	\$ 429	1	
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	32,975	10,928	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625	32,975	40,042	3	
4	19	Professional Fees	Resident Days	277,215	11	118,827	32,975	14,135	4	
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754	32,975	447	5	
6	21	Salaries - Other	Resident Days	277,215	11	1,345,667	1,345,667	32,975	160,068	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853	32,975	58,982	7	
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977	32,975	37,943	8	
9	24	Seminars	Resident Days	277,215	11	34,902	32,975	4,152	9	
10	25	Admin Staff Travel	Resident Days	277,215	11	59,659	32,975	7,096	10	
11	26	Insurance	Resident Days	277,215	11	13,196	32,975	1,570	11	
12	30	Depreciation	Resident Days	277,215	11	47,028	32,975	5,594	12	
13	33	Real Estate Taxes	Resident Days	277,215	11	1,133	32,975	135	13	
14	34	Building Rent	Resident Days	277,215	11	103,521	32,975	12,314	14	
15	34	Rental - Storage Unit	Resident Days	277,215	11	4,139	32,975	492	15	
16	35	Equipment Rental	Resident Days	277,215	11	3,007	32,975	358	16	
17	32	Interest	Resident Days	277,215	11	32,681	32,975	3,887	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 3,014,441	\$ 1,437,534		\$ 358,572	25	

SEE ACCOUNTANTS' COMPILATION REPORT



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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2011 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</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>35,689</b>			2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>35,689</b>			3	
4. Real Estate Tax accrual used for 2012 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>35,689</b>			7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2007	<u>41,587</u>	8	<b>FOR BHF USE ONLY</b>			
	2008	<u>44,953</u>	9	13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
	2009	<u>45,101</u>	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2010	<u>45,874</u>	11	15	LESS REFUND FROM LINE 6	\$	15
	2011	<u>33,800</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>35,689 Line 7, Real Estate Taxes paid in lease payments</b>							
<b>135 Bridgemark Healthcare Allocation</b>							
<b>35,824 Total Schedule V, Line 33</b>							

**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





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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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 HC of Champaign

# 0048181 Report Period Beginning:

1/1/12 Ending:

12/31/12

**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>Section N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Concrete		2006	2,907	291	10	291		1,841
10	Commercial Floor Covering		2006	5,183	518	10	518		3,196
11	Wall A/C Units		2006	3,347		5			3,347
12	Roofing - D & R Roofing		2007	20,600	2,060	10	2,060		12,017
13	Pipes		2007	8,346	417	20	417		2,156
14	Life Safety Detectors & Lighted Exit Sign		2007	3,871	387	10	387		1,982
15	A/C Units		2007	3,039	304	5	304		3,039
16	Heating & A/C/ Compressor & A/C Units		2008	7,072	817	10	817		3,661
17	Roof Top A/C & Roof Repairs		2008	7,347	735	10	735		3,145
18	Door, Signs & Emergency Back-up Lights		2009	4,174	450	15	450		1,498
19	Remodel Hall A, New doors, flooring, rails & upgrade nurses station		2009	14,343	956	15	956		3,586
20	Modern Tile		2010	4,243	424	10	424		1,025
21	Carpet/Tile		2010	9,457	946	10	946		2,049
22	Hot Water Heater		2011	6,504	650	10	650		705
23	Roof Top HVAC unit		2012	6,700	74	15	74		74
24									
25									
26									
27									
28									
29									
30									
31									
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 HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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								70
TOTAL (lines 4 thru 69)		\$ 123,471	\$ 9,029		\$ 9,896	\$ 867	\$ 44,577	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 69,306	\$ 6,478	\$ 10,580	\$ 4,102		\$ 32,662	71
72	Current Year Purchases	3,975	156	550	394		549	72
73	Fully Depreciated Assets	8,566					8,566	73
74								74
75	TOTALS	\$ 81,847	\$ 6,634	\$ 11,130	\$ 4,496		\$ 41,777	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	Van w/ Wheelchair Lift	2008	\$ 5,817	\$ 727	\$ 727	\$	4	\$ 5,817	76
77										77
78	Related Party Allocation - Bridgemark			1,581		395	395	5	1,416	78
79										79
80	TOTALS			\$ 7,398	\$ 727	\$ 1,122	\$ 395		\$ 7,233	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)	\$ 212,716	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,390	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,758	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 93,587	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	Schedule 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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:	118		\$ 170,900			3
4	Additions						4
5	Related Party Allocation-Bridgemark			12,806			5
6	Storage Rental			3,335			6
7	TOTAL	118		\$ 187,041			7

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

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 15,461

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' COMPILATION REPORT

Facility Name & ID Number Helia HC of Champaign # 0048181 Report Period Beginning: 1/1/12 Ending: 12/31/12  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a, 2	hrs	\$		\$	\$	57		\$	57	1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a, 2 & 3	hrs			247		303			550	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					84,133			84,133	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Lab, X-Ray, Therapy</u>	39, 3				413,766					413,766	12
13	Wound Care, Other (specify): <u>Oxygen &amp; Enterals</u>	39, 2						43,498			43,498	13
14	<b>TOTAL</b>			\$		\$	414,013	\$	127,991	\$	542,004	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 HC of Champaign

# 0048181

Report Period Beginning: 1/1/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(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	\$ 1,233	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>215,089</u> )	1,875,328		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,104		7
8	Accounts Receivable (owners or related parties)	1,728,402		8
9	Other(specify): <u>Deposits</u>	180		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,612,247	\$	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	90,940		15
16	Equipment, at Historical Cost	81,428		16
17	Accumulated Depreciation (book methods)	(81,974)		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>	\$ 90,394	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,702,641	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 758,725	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,551		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>Accrued Provider Participation Fees</u>	94,511		36
37	<u>Due to Other Facilities</u>	135,981		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,134,868	\$	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				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,134,868	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,567,773	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,702,641	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,613,788</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior year depreciation adjustment</b>	<b>(164)</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>1,613,624</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>954,149</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>954,149</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>2,567,773</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,247,055	1
2	Discounts and Allowances for all Levels	(77,300)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,169,755</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,253	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 232,253</b>	8
<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		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>\$</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	204	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 204</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vaccines</u>	3,233	28
28a	<u>Vending Income &amp; Refunds</u>	1,596	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 4,829</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,407,041</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	746,264	31
32	Health Care	1,613,636	32
33	General Administration	936,111	33
<b>B. Capital Expense</b>			
34	Ownership	273,951	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	541,397	35
36	Provider Participation Fee	341,533	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>\$ 4,452,892</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>954,149</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 954,149</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 3,907,566	44
45	Private Pay - Net Inpatient Revenue	105,065	45
46	Medicare - Net Inpatient Revenue	1,090,903	46
47	Other-(specify) <u>Insurance</u>	11,075	47
48	Other-(specify) <u>Hospice</u>	55,146	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,169,755</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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' COMPILATION REPORT**

Facility Name & ID Number Helia HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

**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	2,116	2,234	\$ 70,261	\$ 31.45	1
2	Assistant Director of Nursing	366	366	10,844	29.63	2
3	Registered Nurses	7,807	8,467	221,144	26.12	3
4	Licensed Practical Nurses	17,724	18,571	414,730	22.33	4
5	CNAs & Orderlies	48,687	51,968	647,779	12.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,548	1,778	27,415	15.42	8
9	Activity Director					9
10	Activity Assistants	2,657	2,833	33,138	11.70	10
11	Social Service Workers	2,037	2,358	43,587	18.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,731	16,124	173,383	10.75	15
16	Dishwashers					16
17	Maintenance Workers	1,830	2,125	39,050	18.38	17
18	Housekeepers	11,148	12,099	114,901	9.50	18
19	Laundry	1,565	1,626	14,224	8.75	19
20	Administrator	2,656	2,708	107,892	39.84	20
21	Assistant Administrator	1,473	1,625	34,145	21.01	21
22	Other Administrative					22
23	Office Manager					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,345	124,882	\$ 1,952,493 *	\$ 15.63	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	\$ 10,783	1,3	35
36	Medical Director	22,750	9,3	36
37	Medical Records Consultant	1,620	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,508	10,3	39
40	Physical Therapy Consultant	247	10a,3	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	3,383	11,3	44
45	Social Service Consultant	2,978	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 48,269		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' COMPILATION REPORT



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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Helia HC of Champaign

# 0048181

Report Period Beginning:

1/1/12

Ending:

12/31/12

## 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 \$2,385
- (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. \$ 33,719 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 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. \$ 341,533  
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.
- (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. \$ N/A 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

## SEE ACCOUNTANTS' COMPILATION REPORT



Helia Healthcare of Champaign  
Attachment to Schedule XII B  
Equipment Rentals  
12/31/2012

Description		
16A	Nursing Equipment	\$ 1,612
16B	Dietary Equipment	948
16C	Copier Lease	12,543
16D	Related Party Allocation - Bridgemark	358
		<u>\$ 15,461</u>