FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0048181

Facility Name: Helia Hlthcare of Champaign

Address: 1915 South Mattis St (Number) Champaign (City) 61821 (Zip Code)

County: Champaign

Telephone Number: (217)352-0516 **Fax #** (217)352-0976

HFS ID Number:

Date of Initial License for Current Owners: 05/01/06

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618)465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, Il 62002
(Telephone) (618)465-7717 Fax # (618)465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	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	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,394	1,095	3,449	26,938	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,394	1,095	3,449	26,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.54%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 5/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 2,932

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	164,906	18,412	6,397	189,715		189,715		189,715			1
2	Food Purchase		166,951		166,951		166,951	(34)	166,917			2
3	Housekeeping	111,191	16,249	425	127,865		127,865		127,865			3
4	Laundry	15,517	8,710		24,227		24,227		24,227			4
5	Heat and Other Utilities			122,713	122,713		122,713	(14,528)	108,185			5
6	Maintenance	39,300	9,959	50,648	99,907		99,907		99,907			6
7	Other (specify):*											7
8	**TOTAL General Services**	330,914	220,281	180,183	731,378		731,378	(14,562)	716,816			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,184,715	87,321	24,688	1,296,724		1,296,724	6,243	1,302,967			10
10a	Therapy											10a
11	Activities	34,422	5,802	3,260	43,484		43,484	(1,088)	42,396			11
12	Social Services	27,613	41	2,921	30,575		30,575		30,575			12
13	CNA Training											13
14	Program Transportation			6,092	6,092		6,092		6,092			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,246,750	93,164	57,961	1,397,875		1,397,875	5,155	1,403,030			16
	C. General Administration											
17	Administrative	124,649		230,800	355,449		355,449	(199,625)	155,824			17
18	Directors Fees											18
19	Professional Services			23,240	23,240	(1,064)	22,176	9,891	32,067			19
20	Dues, Fees, Subscriptions & Promotions			26,716	26,716	1,064	27,780	(12,075)	15,705			20
21	Clerical & General Office Expenses	5,832	8,761	42,883	57,476		57,476	187,994	245,470			21
22	Employee Benefits & Payroll Taxes			323,249	323,249		323,249	25,277	348,526			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,461	1,461		1,461	5,818	7,279			24
25	Other Admin. Staff Transportation			11,475	11,475		11,475	4,357	15,832			25
26	Insurance-Prop.Liab.Malpractice			40,446	40,446		40,446	2,492	42,938			26
27	Other (specify):*											27
28	**TOTAL General Administration**	130,481	8,761	700,270	839,512		839,512	24,129	863,641			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,708,145	322,206	938,414	2,968,765		2,968,765	14,722	2,983,487			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 Hlthcare of Champaign #0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,307	15,307		15,307	5,068	20,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,238	34,238		34,238	(34,238)				32
33	Real Estate Taxes			43,545	43,545		43,545	39	43,584			33
34	Rent-Facility & Grounds			198,258	198,258		198,258	10,766	209,024			34
35	Rent-Equipment & Vehicles			12,005	12,005		12,005		12,005			35
36	Other (specify):*											36
37	TOTAL Ownership			303,353	303,353		303,353	(18,365)	284,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,462	499,471	620,933		620,933		620,933			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			217,063	217,063		217,063		217,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		121,462	716,534	837,996		837,996		837,996			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,708,145	443,668	1,958,301	4,110,114		4,110,114	(3,643)	4,106,471			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 Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,088)	11		4
5	Telephone, TV & Radio in Resident Rooms	(14,750)	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	(34,238)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,298)	21		19
20	Contributions	(115)	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	(13,308)	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	(5,297)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,128)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	69,485	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 69,485		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,643)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Helia Hlthcare of Champaign

ID# 0048181

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (1,465)	20	1
2	Offset Medical Records Income	(272)	10	2
3	Eliminate Out-of-period costs	(5,550)	19	3
4	IDPH License Fee	1,990	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,297)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(34)	0	0	0	0	0	0	0	0	0	0	(34)	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	(14,750)	222	0	0	0	0	0	0	0	0	0	(14,528)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,784)	222	0	0	0	0	0	0	0	0	0	(14,562)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(272)	6,515	0	0	0	0	0	0	0	0	0	6,243	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,088)	0	0	0	0	0	0	0	0	0	0	(1,088)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,360)	6,515	0	0	0	0	0	0	0	0	0	5,155	16
	C. General Administration													
17	Administrative	0	(199,625)	0	0	0	0	0	0	0	0	0	(199,625)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,550)	15,441	0	0	0	0	0	0	0	0	0	9,891	19
20	Fees, Subscriptions & Promotions	(12,783)	708	0	0	0	0	0	0	0	0	0	(12,075)	20
21	Clerical & General Office Expenses	(4,413)	192,407	0	0	0	0	0	0	0	0	0	187,994	21
22	Employee Benefits & Payroll Taxes	0	25,277	0	0	0	0	0	0	0	0	0	25,277	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,818	0	0	0	0	0	0	0	0	0	5,818	24
25	Other Admin. Staff Transportation	0	4,357	0	0	0	0	0	0	0	0	0	4,357	25
26	Insurance-Prop.Liab.Malpractice	0	2,492	0	0	0	0	0	0	0	0	0	2,492	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,746)	46,875	0	0	0	0	0	0	0	0	0	24,129	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,890)	53,612	0	0	0	0	0	0	0	0	0	14,722	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	5,068	0	0	0	0	0	0	0	0	0	5,068	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34,238)	0	0	0	0	0	0	0	0	0	0	(34,238)	32
33	Real Estate Taxes	0	39	0	0	0	0	0	0	0	0	0	39	33
34	Rent-Facility & Grounds	0	10,766	0	0	0	0	0	0	0	0	0	10,766	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(34,238)	15,873	0	0	0	0	0	0	0	0	0	(18,365)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(73,128)	69,485	0	0	0	0	0	0	0	0	0	(3,643)	45

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical Supply	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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 222	$ 222	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	6,515	6,515	2
3	V	17	Administrative	230,800	Bridgemark Healthcare, LLC	100.00%	31,175	(199,625)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	15,441	15,441	4
5	V	20	Dues, Subscriptions, & Fees		Bridgemark Healthcare, LLC	100.00%	708	708	5
6	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	192,407	192,407	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	25,277	25,277	7
8	V	24	Travel & Seminars		Bridgemark Healthcare, LLC	100.00%	5,818	5,818	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,357	4,357	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,492	2,492	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	5,068	5,068	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	39	39	12
13	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	10,766	10,766	13
14	Total			$ 230,800			$ 300,285	$ * 69,485	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	270,414	5.17	10.34	Distribution	$ 31,175	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	$ 31,175		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 Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	260,600	10	$ 2,150	$	26,938	$ 222	1
2	10	Nursing & Medical Records	Resident Days	260,600	10	63,025	63,025	26,938	6,515	2
3	17	Owners Compensation	Resident Days	260,600	10	301,589		26,938	31,175	3
4	19	Professional Fees	Resident Days	260,600	10	149,373		26,938	15,441	4
5	20	Dues, Subscriptions	Resident Days	260,600	10	6,850		26,938	708	5
6	21	Salaries - Other	Resident Days	260,600	10	1,295,190	1,295,190	26,938	133,883	6
7	21	Clerical & Office Supplies	Resident Days	260,600	10	566,161		26,938	58,524	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	260,600	10	244,527		26,938	25,277	8
9	24	Seminars	Resident Days	260,600	10	56,285		26,938	5,818	9
10	25	Admin Staff Travel	Resident Days	260,600	10	42,147		26,938	4,357	10
11	26	Insurance	Resident Days	260,600	10	24,107		26,938	2,492	11
12	30	Depreciation	Resident Days	260,600	10	49,028		26,938	5,068	12
13	33	Real Estate Taxes	Resident Days	260,600	10	374		26,938	39	13
14	34	Building Rent	Resident Days	260,600	10	95,749		26,938	9,897	14
15	34	Rental - Storage Unit	Resident Days	260,600	10	8,407		26,938	869	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,904,962	$ 1,358,215		$ 300,285	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	34,238	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 34,238	9
	B. Non-Facility Related*											
10	Interest Income		X								(34,238)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (34,238)	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 43,545	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43,545	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 43,545	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	44,953	8
	2009	45,101	9
	2010	45,874	10
	2011	33,800	11
	2012	35,282	12

43,545 Line 7, Real Estate Taxes Paid in lease payments
39 Bridgemark Healthcare Allocation
43,584 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Hlthcare 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	45-20-22-282-005	Long Term Care	$ 35,281.50	$ 35,281.50
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,281.50	$ 35,281.50

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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. [X] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Concrete			2006	2,907	291	10	291			9
10	Commercial Floor Covering			2006	5,183	518	10	518			10
11	Wall A/C Units			2006	3,347		5				11
12	Roofing - D & R Roofing			2007	20,600	2,060	10	2,060			12
13	Pipes			2007	8,346	417	20	417			13
14	Life Saftey Detectors & Lighted Exit Sign			2007	3,871	387	10	387			14
15	A/C Units			2007	3,039		5				15
16	Heating & A/C/ Compressor & A/C Units			2008	7,072	671	10	671			16
17	Roof Top A/C & Roof Repairs			2008	7,347	735	10	735			17
18	Door, Signs & Emergency Back-up Lights			2009	4,174	449	15	449			18
19	Remodel Hall A, New doors, flooring, rails & upgrade nurses station			2009	14,343	956	15	956			19
20	Modern Tile			2010	4,243	424	10	424			20
21	Carpet/Tile			2010	9,457	946	10	946			21
22	Hot Water Heater			2011	6,504	650	10	650			22
23	Roof Top HVAC unit			2012	6,700	447	15	447			23
24	Fire Alarm Panel			2013	7,938	661	5	661			24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation - Bridgemark Healthcare		$	$		$	$	$	37
38	New Office Build-Out	2011	14,039		20	743	743	1,824	38
39	Conference Rm Chair Rail & Paint	2012	159		5	32	32	42	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)		$ 129,269	$ 9,612		$ 10,387	$ 775	$ 1,866	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 Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 14,302	$ 5,695	$ 9,366	$ 3,671	3-15	$ 7,333	71
72	Current Year Purchases	1,785		479	479	3-15	479	72
73	Fully Depreciated Assets	208					208	73
74								74
75	TOTALS	$ 16,295	$ 5,695	$ 9,845	$ 4,150		$ 8,020	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				$	$	$	$		$	76
77										77
78	Related Party Allocation - Bridgemark			1,374		143	143	5	1,374	78
79										79
80	TOTALS			$ 1,374	$	$ 143	$ 143		$ 1,374	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)	$ 146,938	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,307	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,375	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,068	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,260	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

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118		$ 195,634			3
4	Additions							4
5	Related Party Allocation-Bridgemark				10,766			5
6	Storage Rental				2,624			6
7	TOTAL		118		$ 209,024 **			7

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

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

16. Rental Amount for movable equipment: $ 12,005 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 Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				97,024		97,024	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					24,438		24,438	12
13	Other (specify): Lab, Xray, Therapy	39,3				499,471			499,471	13
14	TOTAL			$		$ 499,471	$ 121,462		$ 620,933	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

STATE OF ILLINOIS

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,269	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (118,200))	1,332,850		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,103		7
8	Accounts Receivable (owners or related parties)	2,720,539		8
9	Other(specify):	73,680		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,133,441	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	35,608		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 35,608	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,169,049	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 379,999	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,478		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,533		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,608		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	34,563		36
37	Due to Related Parties	130,464		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 700,645	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 700,645	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,468,404	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,169,049	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,567,773	1
2	Restatements (describe):		2
3	**Prior Year Adjustements made after cost reports finalized**	12,970	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,580,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	887,661	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 887,661	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,468,404	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,402,660	1
2	Discounts and Allowances for all Levels	(70,219)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,332,441	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	198,043	6
7	Oxygen	2,813	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 200,856	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,088	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,088	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	74,565	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74,565	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	381,051	27
28	Miscellaneous	7,502	28
28a	Medical Record Copies	272	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 388,825	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,997,775	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	731,378	31
32	Health Care	1,390,976	32
33	General Administration	846,411	33
	B. Capital Expense		
34	Ownership	303,353	34
	C. Ancillary Expense		
35	Special Cost Centers	620,933	35
36	Provider Participation Fee	217,063	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,110,114	40
41	**Income before Income Taxes (line 30 minus line 40)****	887,661	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 887,661	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,770,545	44
45	Private Pay - Net Inpatient Revenue	118,171	45
46	Medicare - Net Inpatient Revenue	1,348,935	46
47	Other-(specify) Insurance	44,657	47
48	Other-(specify) Hospice	50,133	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,332,441	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,171	2,258	$ 70,252	$ 31.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,522	5,778	152,817	26.45	3
4	Licensed Practical Nurses	15,658	16,674	384,461	23.06	4
5	CNAs & Orderlies	39,485	43,011	544,485	12.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,793	2,076	32,700	15.75	8
9	Activity Director					9
10	Activity Assistants	2,578	2,792	34,422	12.33	10
11	Social Service Workers	1,984	2,111	27,613	13.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,881	15,042	164,906	10.96	15
16	Dishwashers					16
17	Maintenance Workers	1,720	2,080	39,300	18.89	17
18	Housekeepers	10,693	11,366	111,191	9.78	18
19	Laundry	1,683	1,790	15,517	8.67	19
20	Administrator	2,828	3,013	115,890	38.46	20
21	Assistant Administrator	372	408	8,759	21.47	21
22	Other Administrative		583	5,832	10.00	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)	100,368	108,982	$ 1,708,145 *	$ 15.67	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,397	1,3	35
36	Medical Director		21,000	9,3	36
37	Medical Records Consultant		2,895	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,508	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,260	11,3	44
45	Social Service Consultant		2,921	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,981		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Araceli Henson	Administrator	0	$ 115,890
Brenda Dively	Asst. Administrator	0	8,759
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 124,649

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 230,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 230,800

C. Professional Services

Vendor/Payee	Type	Amount
S.J. Schlosser & Company, LLC	Accounting Services	$ 3,010
Ceridian	Payroll Processing	11,252
Much Shelist	Out-of-period Legal Fees	5,550
Personnel Planners, Inc.	Unemployment Consultants	1,674
Hamlin & Burton	MSP Reporting	650
Kramer & Frank	Legal Fees	40
Centers for Medicare	Revalidation Fees	1,064
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,240

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,521
Unemployment Compensation Insurance	85,671
FICA Taxes	130,973
Employee Health Insurance	28,769
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	6,062
Employee Benefits	2,293
Employee Insurance	3,960
Related Party Allocation-Bridgemark	25,277
TOTAL (agree to Schedule V, line 22, col.8)	$ 348,526

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,715
Health Care Worker Background Check	
(Indicate # of checks performed)	2,440
Patient Background Checks	
Dues & Subscriptions	1,946
Late Fees	2,301
Miscellaneous Licenses & Fees	605
Related Party Allocation-Bridgemark	708
Advertising	13,308
Less: Public Relations Expense	( )
Non-allowable advertising	(13,308)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,705

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	68
Seminar Expense	1,393
Related Pary Allocation-Bridgemark	5,818
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,279

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	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 & ID Number Helia Hlthcare of Champaign # 0048181 Report Period Beginning: 1/1/13 Ending: 12/31/13

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **27,072** 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. $ **217,063**
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. $ **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 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 XII B
Equipment Rentals
12/31/2013

	Description	
16A	Nursing Equipment	$ 1,477
16B	Dietary Equipment	316
16C	Copier Lease	10,212
		$ 12,005