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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048181

Facility Name: Helia Healthcare of Champaign

Address: 1915 South Mattis Street (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 01/01/11 to 12/31/11 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 East 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 Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	27,598	1,809	2,866	32,273	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,598	1,809	2,866	32,273	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.93%

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 2,488

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: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,992	19,459	9,214	207,665		207,665		207,665			1
2	Food Purchase		186,697		186,697		186,697	(52)	186,645			2
3	Housekeeping	112,069	19,252		131,321		131,321		131,321			3
4	Laundry	30,328	15,107		45,435		45,435		45,435			4
5	Heat and Other Utilities			116,663	116,663		116,663	(9,584)	107,079			5
6	Maintenance	38,508	10,797	42,830	92,135		92,135		92,135			6
7	Other (specify):*											7
8	TOTAL General Services	359,897	251,312	168,707	779,916		779,916	(9,636)	770,280			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,513,179	123,002	8,083	1,644,264		1,644,264	16,340	1,660,604			10
10a	Therapy		404		404		404		404			10a
11	Activities	39,972	3,438	2,182	45,592		45,592	(1,336)	44,256			11
12	Social Services	35,416	68	2,007	37,491		37,491		37,491			12
13	CNA Training											13
14	Program Transportation			1,059	1,059		1,059		1,059			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,588,567	126,912	34,331	1,749,810		1,749,810	15,004	1,764,814			16
	C. General Administration											
17	Administrative	110,658		255,681	366,339		366,339	(214,555)	151,784			17
18	Directors Fees											18
19	Professional Services			32,403	32,403	(6,278)	26,125	9,935	36,060			19
20	Dues, Fees, Subscriptions & Promotions			27,515	27,515		27,515	(13,442)	14,073			20
21	Clerical & General Office Expenses	44,780	15,315	55,464	115,559		115,559	171,637	287,196			21
22	Employee Benefits & Payroll Taxes			405,392	405,392		405,392	31,678	437,070			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,370	1,370		1,370	585	1,955			24
25	Other Admin. Staff Transportation			10,252	10,252		10,252	14,197	24,449			25
26	Insurance-Prop.Liab.Malpractice			54,814	54,814		54,814	1,148	55,962			26
27	Other (specify):*											27
28	TOTAL General Administration	155,438	15,315	842,891	1,013,644	(6,278)	1,007,366	1,183	1,008,549			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,103,902	393,539	1,045,929	3,543,370	(6,278)	3,537,092	6,551	3,543,643			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Helia Healthcare of Champaign #0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			17,508	17,508		17,508	5,106	22,614			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,100	3,100		3,100	(180)	2,920			32
33	Real Estate Taxes			43,440	43,440	6,278	49,718	54	49,772			33
34	Rent-Facility & Grounds			186,820	186,820		186,820	10,714	197,534			34
35	Rent-Equipment & Vehicles			9,958	9,958		9,958	320	10,278			35
36	Other (specify):*											36
37	**TOTAL Ownership**			260,826	260,826	6,278	267,104	16,014	283,118			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,279	437,938	555,217		555,217	(1,106)	554,111			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		117,279	502,543	619,822		619,822	(1,106)	618,716			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,103,902	510,818	1,809,298	4,424,018		4,424,018	21,459	4,445,477			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 Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,336)	11		4
5	Telephone, TV & Radio in Resident Rooms	(9,995)	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	(180)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,106)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(5,590)	21		18
19	Entertainment	(3,642)	21		19
20	Contributions	(75)	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	(10,240)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,002)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,218)		$	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)	60,677	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 60,677		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 21,459		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Champaign

ID# 0048181

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (2,360)	20	1
2	Eliminate PAC Dues & Lobbying Expense	(2,870)	20	2
3	Offset Medical Records Income	(279)	10	3
4	Eliminate overaccrued IDPH License Fees	(1,493)	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**	(7,002)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Champaign **#** 0048181 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	(52)	0	0	0	0	0	0	0	0	0	0	(52)	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	(9,995)	411	0	0	0	0	0	0	0	0	0	(9,584)	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**	(10,047)	411	0	0	0	0	0	0	0	0	0	(9,636)	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	(279)	16,619	0	0	0	0	0	0	0	0	0	16,340	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,336)	0	0	0	0	0	0	0	0	0	0	(1,336)	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**	(1,615)	16,619	0	0	0	0	0	0	0	0	0	15,004	16
	C. General Administration													
17	Administrative	0	(214,555)	0	0	0	0	0	0	0	0	0	(214,555)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,935	0	0	0	0	0	0	0	0	0	9,935	19
20	Fees, Subscriptions & Promotions	(16,963)	3,521	0	0	0	0	0	0	0	0	0	(13,442)	20
21	Clerical & General Office Expenses	(9,307)	180,944	0	0	0	0	0	0	0	0	0	171,637	21
22	Employee Benefits & Payroll Taxes	0	31,678	0	0	0	0	0	0	0	0	0	31,678	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	585	0	0	0	0	0	0	0	0	0	585	24
25	Other Admin. Staff Transportation	0	14,197	0	0	0	0	0	0	0	0	0	14,197	25
26	Insurance-Prop.Liab.Malpractice	0	1,148	0	0	0	0	0	0	0	0	0	1,148	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,270)	27,453	0	0	0	0	0	0	0	0	0	1,183	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,932)	44,483	0	0	0	0	0	0	0	0	0	6,551	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Champaign **#** 0048181 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	5,106	0	0	0	0	0	0	0	0	0	5,106	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(180)	0	0	0	0	0	0	0	0	0	0	(180)	32
33	Real Estate Taxes	0	54	0	0	0	0	0	0	0	0	0	54	33
34	Rent-Facility & Grounds	0	10,714	0	0	0	0	0	0	0	0	0	10,714	34
35	Rent-Equipment & Vehicles	0	0	320	0	0	0	0	0	0	0	0	320	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(180)	15,874	320	0	0	0	0	0	0	0	0	16,014	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	(1,106)	0	0	0	0	0	0	0	0	0	0	(1,106)	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**	(1,106)	0	0	0	0	0	0	0	0	0	0	(1,106)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(39,218)	60,357	320	0	0	0	0	0	0	0	0	21,459	45

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 411	$ 411	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	16,619	16,619	2
3	V	17	Administrative	255,681	Bridgemark Healthcare, LLC	100.00%	41,126	(214,555)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	9,935	9,935	4
5	V	20	Dues, Subscriptions, & Fees		Bridgemark Healthcare, LLC	100.00%	3,521	3,521	5
6	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	180,944	180,944	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	31,678	31,678	7
8	V	24	Travel & Seminars		Bridgemark Healthcare, LLC	100.00%	585	585	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	14,197	14,197	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,148	1,148	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	5,106	5,106	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	54	54	12
13	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	10,714	10,714	13
14	Total			$ 255,681			$ 316,038	$ * 60,357	14

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 320	$ 320	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 320	$ * 320	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			Helia Healthcare of Rolla	Rolla, MO				2
3			Hillside Rehab & Care Center	Yorkville, IL				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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	333,874	5	10.97	Distribution	$ 41,126	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	$ 41,126		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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1 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	294,279	12	$ 3,751	$	32,273	$ 411	1
2	10	Nursing & Medical Records	Resident Days	294,279	12	151,540	151,540	32,273	16,619	2
3	17	Owners Compensation	Resident Days	294,279	12	375,000		32,273	41,126	3
4	19	Professional Fees	Resident Days	294,279	12	90,588		32,273	9,935	4
5	20	Dues, Subscriptions	Resident Days	294,279	12	32,105		32,273	3,521	5
6	21	Salaries - Other	Resident Days	294,279	12	1,135,681	1,135,681	32,273	124,548	6
7	21	Clerical & Office Supplies	Resident Days	294,279	12	514,247		32,273	56,396	7
8	22	Emp Ben & Payroll Taxes	Resident Days	294,279	12	288,855		32,273	31,678	8
9	24	Seminars	Resident Days	294,279	12	5,335		32,273	585	9
10	25	Admin Staff Transportation	Resident Days	294,279	12	129,453		32,273	14,197	10
11	26	Insurance	Resident Days	294,279	12	10,464		32,273	1,148	11
12	30	Depreciation	Resident Days	294,279	12	46,555		32,273	5,106	12
13	33	Real Estate Taxes	Resident Days	294,279	12	492		32,273	54	13
14	34	Building Rent	Resident Days	294,279	12	94,784		32,273	10,395	14
15	34	Rental - Storage Unit	Resident Days	294,279	12	2,905		32,273	319	15
16	35	Euipment Rental	Resident Days	294,279	12	2,920		32,273	320	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,884,675	$ 1,287,221		$ 316,358	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	3,100	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 3,100	9
	B. Non-Facility Related*											
10	Interest Income		X								(180)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (180)	14
15	TOTALS (line 9+line14)						$	$			$ 2,920	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 Healthcare of Champaign **#** 0048181 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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.)		$ 43,440	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43,440	3
4. Real Estate Tax accrual used for 2011 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.**		$ 6,278	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.		$ 49,718	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	40,884	8
	2007	41,587	9
	2008	44,953	10
	2009	45,101	11
	2010	45,874	12

49,718 Line 7, Real Estate Taxes included in Lease Payments & Legal Costs
54 Bridgemark Healthcare Allocation
49,772 Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0048181

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(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	$ 45,874.02	$ 45,874.02
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,874.02	$ 45,874.02

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Schedule N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		1,551	9
10	Commercial Floor Covering			2006	5,183	518	10	518		2,677	10
11	Wall A/C Units			2006	3,347	445	5	445		3,347	11
12	Roofing - D & R Roofing			2007	20,600	2,060	10	2,060		9,957	12
13	Pipes			2007	8,346	417	20	417		1,738	13
14	Life Saftey Detectors & Lighted Exit Sign			2007	3,871	387	10	387		1,595	14
15	A/C Units			2007	3,039	607	5	607		2,734	15
16	Heating & A/C/ Compressor & A/C Units			2008	7,072	817	10	817		2,845	16
17	Roof Top A/C & Roof Repairs			2008	7,347	735	10	735		2,410	17
18	Door, Signs & Emergency Back-up Lights			2009	4,175	450	15	450		1,051	18
19	Remodel Hall A, New doors, flooring, rails & upgrade nurses station			2009	14,343	956	15	956		2,629	19
20	Modern Tile			2010	4,243	424	10	424		601	20
21	Carpet/Tile			2010	9,457	946	10	946		1,104	21
22	Hot Water Heater			2011	6,504	54	10	54		54	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

*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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	14,895		20	358	358	358	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 115,329	$ 9,107		$ 9,465	$ 358	$ 34,651	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 55,219	$ 6,437	$ 9,516	$ 3,079	5-10	$ 29,875	71
72	Current Year Purchases	22,812	510	1,617	1,107	5-10	1,617	72
73	Fully Depreciated Assets	62					62	73
74								74
75	TOTALS	$ 78,093	$ 6,947	$ 11,133	$ 4,186		$ 31,554	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	$ 1,454	$ 1,454	$	4	$ 5,089	76
77										77
78	Related Party Allocation - Bridgemark			1,457		562	562	5	941	78
79										79
80	TOTALS			$ 7,274	$ 1,454	$ 2,016	$ 562		$ 6,030	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)	$ 200,696	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,508	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,614	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,106	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 72,235	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$ 182,400			3
4	Additions							4
5	Storage Rental				4,420			5
6	Related Party Allocation - Bridgemark				10,714			6
7	TOTAL		118		$ 197,534 **			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 by the length of the lease N/A . 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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 10,278 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 Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Healthcare of Champaign

STATE OF ILLINOIS
0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 2	hrs	$		$	$ 292		$ 292	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				112		112	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				81,137		81,137	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Ent	39, 2					36,142		36,142	12
13	Physical, Occupational & Speech Ther Other (specify): X-Ray & Lab	39, 3				437,938			437,938	13
14	TOTAL			$		$ 437,938	$ 117,683		$ 555,621	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 Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 500	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 172,226)	1,655,431		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,555		7
8	Accounts Receivable (owners or related parties)	869,799		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,527,285	$	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	84,240		15
16	Equipment, at Historical Cost	80,308		16
17	Accumulated Depreciation (book methods)	(65,420)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 99,128	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,626,413	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 747,678	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,704		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,672		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Other Facilities	135,981		36
37	Accrued CMP Penalties	5,590		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,012,625	$	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)**	$ 1,012,625	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,613,788	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,626,413	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,268,518	1
2	Restatements (describe):		2
3	**Prior year adjustment to record additional rent expense**	(251,936)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,016,582	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	597,206	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)**	$ 597,206	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)**	$ 1,613,788	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,884,539	1
2	Discounts and Allowances for all Levels	(81,790)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,802,749	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	215,124	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 215,124	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	1,336	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)**	$ 1,336	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	180	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 180	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	279	28
28a	Miscellaneous Income	1,556	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,835	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,021,224	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	779,916	31
32	Health Care	1,749,810	32
33	General Administration	1,013,644	33
	B. Capital Expense		
34	Ownership	260,826	34
	C. Ancillary Expense		
35	Special Cost Centers	555,217	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,424,018	40
41	**Income before Income Taxes (line 30 minus line 40)****	597,206	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 597,206	43

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

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

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

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,080	2,080	$ 74,989	$ 36.05	1
2	Assistant Director of Nursing	867	920	18,666	20.29	2
3	Registered Nurses	6,511	6,835	182,418	26.69	3
4	Licensed Practical Nurses	20,670	21,602	490,244	22.69	4
5	CNAs & Orderlies	53,553	56,315	684,495	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,957	2,256	34,174	15.15	8
9	Activity Director					9
10	Activity Assistants	3,480	3,771	39,972	10.60	10
11	Social Service Workers	1,881	1,905	35,416	18.59	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,160	31,652	14.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,578	14,659	147,340	10.05	15
16	Dishwashers					16
17	Maintenance Workers	1,890	2,084	38,508	18.48	17
18	Housekeepers	10,855	11,920	112,069	9.40	18
19	Laundry	2,772	2,881	30,328	10.53	19
20	Administrator	2,080	2,080	68,817	33.09	20
21	Assistant Administrator	2,080	2,080	41,841	20.12	21
22	Other Administrative					22
23	Office Manager	1,677	1,760	44,780	25.44	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	1,771	1,956	28,193	14.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,622	137,264	$ 2,103,902 *	$ 15.33	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		$ 9,214	1, 3	35
36	Medical Director		21,000	9, 3	36
37	Medical Records Consultant		2,426	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,657	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,182	11, 3	44
45	Social Service Consultant		2,007	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 42,486		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 Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Araceli Henson	Administrator	0	$ 68,817
Brenda Dively	Asst. Admin	0	41,841
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,658

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 255,681
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 255,681

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,120
Ceridian	Payroll Processing	11,524
Much Shelist	Legal Fees	10,416
Honkamp Krueger	Legal Fees	65
Allen Lefkovitz & Assoc	Real Estate Assessment Fee	6,278
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 32,403

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,205
Unemployment Compensation Insurance	9,686
FICA Taxes	238,945
Employee Health Insurance	48,534
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k) Match	4,626
Employee Relations	111
Uniforms	1,285
Related Party Allocation - Bridgemark	31,678
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,070

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	506
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	2,082
Dues & Subscriptions	4,557
Advertising	10,240
Late Fees	850
Misc. Fees & Licenses	567
Related Party Allocation - Bridgemark	3,521
Less: Public Relations Expense	( )
Non-allowable advertising	(10,240)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,073

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,370
Related Party Allocation - Bridgemark	585
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,955

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Healthcare of Champaign **#** 0048181 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,210**

(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. $ **27,667** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **64,605**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Champaign
Attachment to Schedule XII B
Equipment Rentals
12/31/2011

	Description	
16A	Nursing Equipment Rental	$ 3,604
16B	Copier Lease	5,406
16C	Dietary Equipment Rental	948
16D	Related Party Allocation - Bridgemark	320
		$ 10,278