

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: <u>0048181</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Helia HC of Champaign</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.																							
Address: <u>1915 S Mattis St</u> <u>Champaign</u> <u>61821</u>																									
Number City Zip Code																									
County: <u>Champaign</u>																									
Telephone Number: <u>(217)352-0516</u> Fax # <u>(217)352-0976</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Michael Parentin</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td>(Signed) <u>See Accountant's Compilation Report</u></td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Michael Parentin</u>	(Title) <u>Chief Financial Officer</u>	(Signed) <u>See Accountant's Compilation Report</u>	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Michael Parentin</u>																								
	(Title) <u>Chief Financial Officer</u>																								
	(Signed) <u>See Accountant's Compilation Report</u>																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>05/01/06</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618)465-7717</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia HC of Champaign

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>118</u>	Skilled (SNF)	<u>118</u>	<u>43,188</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,188</u>	7

B. Census-For the entire report period.

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

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

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 118 and days of care provided 2,367

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			16,390	16,390		16,390	5,758	22,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,534	32,534		32,534	3,683	36,217			32
33	Real Estate Taxes			35,689	35,689		35,689	135	35,824			33
34	Rent-Facility & Grounds			174,235	174,235		174,235	12,806	187,041			34
35	Rent-Equipment & Vehicles			15,103	15,103		15,103	358	15,461			35
36	Other (specify):*											36
37	TOTAL Ownership			273,951	273,951		273,951	22,740	296,691			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,631	413,766	541,397		541,397		541,397			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			341,533	341,533		341,533		341,533			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		127,631	755,299	882,930		882,930		882,930			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,952,493	482,738	2,017,661	4,452,892		4,452,892	57,007	4,509,899			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,269)	11		4
5	Telephone, TV & Radio in Resident Rooms	(10,177)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	164	30		9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds	(327)	10a		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,696)	21		18
19	Entertainment	(3,217)	21		19
20	Contributions	(436)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,452)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,520)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (39,165)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 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)	96,172	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 96,172		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 57,007		37

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

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

		1 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 HC of Champaign

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Gifts & Flowers	\$ (2,927)	20	1
2	Eliminate Lobbying & PAC Dues	(1,603)	20	2
3	Out of Period IDPH license fee	(1,990)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,520)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(31)	0	0	0	0	0	0	0	0	0	0	(31)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,177)	429	0	0	0	0	0	0	0	0	0	(9,748)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,208)	429	0	0	0	0	0	0	0	0	0	(9,779)	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	0	10,928	0	0	0	0	0	0	0	0	0	10,928	10
10a	Therapy	(327)	0	0	0	0	0	0	0	0	0	0	(327)	10a
11	Activities	(1,269)	0	0	0	0	0	0	0	0	0	0	(1,269)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,596)	10,928	0	0	0	0	0	0	0	0	0	9,332	16
	C. General Administration													
17	Administrative	0	(222,358)	0	0	0	0	0	0	0	0	0	(222,358)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,135	0	0	0	0	0	0	0	0	0	14,135	19
20	Fees, Subscriptions & Promotions	(19,972)	447	0	0	0	0	0	0	0	0	0	(19,525)	20
21	Clerical & General Office Expenses	(7,349)	219,050	0	0	0	0	0	0	0	0	0	211,701	21
22	Employee Benefits & Payroll Taxes	0	37,943	0	0	0	0	0	0	0	0	0	37,943	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,152	0	0	0	0	0	0	0	0	0	4,152	24
25	Other Admin. Staff Transportation	0	7,096	0	0	0	0	0	0	0	0	0	7,096	25
26	Insurance-Prop.Liab.Malpractice	0	1,570	0	0	0	0	0	0	0	0	0	1,570	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,321)	62,035	0	0	0	0	0	0	0	0	0	34,714	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(39,125)	73,392	0	0	0	0	0	0	0	0	0	34,267	29

Summary B

12/31/12

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100%	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 358	\$ 358	15
16	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	3,887	3,887	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 4,245	\$ * 4,245	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Helia Southbelt Healthcare	Belleville, IL				2
3			Hillside Rehab & Care Center	Yorkville, IL				3
4			Helia Healthcare of Rolla	Rolla, MO				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	296,583	5.95	11.90	Distribution	\$ 40,042	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 40,042		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09					Variable	32,534	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 32,534	9
	B. Non-Facility Related*												
10	Interest Income		X									(204)	10
11	Related Party Allocation - Bridgemark Healthcare											3,887	11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ 3,683	14
15	TOTALS (line 9+line14)						\$		\$			\$ 36,217	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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.)		\$	35,689		2
3. Under or (over) accrual (line 2 minus line 1).		\$	35,689		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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.		\$	35,689		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	41,587	8	
		2008	44,953	9	
		2009	45,101	10	
		2010	45,874	11	
		2011	33,800	12	
35,689 Line 7, Real Estate Taxes paid in lease payments					
135 Bridgemark Healthcare Allocation					
35,824 Total Schedule V, Line 33					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia HC 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 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	45-20-22-282-005	Long Term Care	\$ 33,799.68	\$ 33,799.68
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 33,799.68	\$ 33,799.68

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

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

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

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	16,155		20	855	855	1,244	38
39	Conference Rm Chair Rail & Paint	2012	183		5	12	12	12	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)		\$ 123,471	\$ 9,029		\$ 9,896	\$ 867	\$ 44,577	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$69,306	\$6,478	\$10,580	\$4,102		\$32,662	71
72	Current Year Purchases	3,975	156	550	394		549	72
73	Fully Depreciated Assets	8,566					8,566	73
74								74
75	TOTALS	\$81,847	\$6,634	\$11,130	\$4,496		\$41,777	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van w/ Wheelchair Lift	2008	\$5,817	\$727	\$727		4	\$5,817	76
77										77
78	Related Party Allocation - Bridgemark			1,581		395	395	5	1,416	78
79										79
80	TOTALS			\$7,398	\$727	\$1,122	\$395		\$7,233	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$212,716	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$16,390	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$22,148	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$5,758	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$93,587	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:First Healthcare Associates
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118		\$ 170,900			3
4	Additions							4
5	Related Party Allocation-Bridgemark				12,806			5
6	Storage Rental				3,335			6
7	TOTAL		118		\$ 187,041			7

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

9. Option to Buy:☐ YES☒ NOTerms: *

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

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 15,461Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

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
☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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	\$		\$	57		\$ 57	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2 & 3	hrs			247	303		550	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				84,133		84,133	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab, X-Ray, Therapy	39, 3				413,766			413,766	12
13	Wound Care, Other (specify): Oxygen & Enterals	39, 2					43,498		43,498	13
14	TOTAL			\$		\$ 414,013	\$ 127,991		\$ 542,004	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,233	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 215,089)	1,875,328		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,104		7
8	Accounts Receivable (owners or related parties)	1,728,402		8
9	Other(specify): Deposits	180		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,612,247	\$	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	90,940		15
16	Equipment, at Historical Cost	81,428		16
17	Accumulated Depreciation (book methods)	(81,974)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 90,394	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,702,641	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 758,725	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,551		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Participation Fees	94,511		36
37	Due to Other Facilities	135,981		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,134,868	\$	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)	\$ 1,134,868	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,567,773	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,702,641	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,613,788	1
2	Restatements (describe):		2
3	Prior year depreciation adjustment	(164)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,613,624	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	954,149	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)	\$ 954,149	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)	\$ 2,567,773	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,247,055	1
2	Discounts and Allowances for all Levels	(77,300)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,169,755	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,253	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 232,253	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	204	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 204	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vaccines	3,233	28
28a	Vending Income & Refunds	1,596	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,829	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,407,041	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	746,264	31
32	Health Care	1,613,636	32
33	General Administration	936,111	33
	B. Capital Expense		
34	Ownership	273,951	34
	C. Ancillary Expense		
35	Special Cost Centers	541,397	35
36	Provider Participation Fee	341,533	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,452,892	40
41	Income before Income Taxes (line 30 minus line 40)**	954,149	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 954,149	43

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

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,116	2,234	\$ 70,261	\$ 31.45	1
2	Assistant Director of Nursing	366	366	10,844	29.63	2
3	Registered Nurses	7,807	8,467	221,144	26.12	3
4	Licensed Practical Nurses	17,724	18,571	414,730	22.33	4
5	CNAs & Orderlies	48,687	51,968	647,779	12.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,548	1,778	27,415	15.42	8
9	Activity Director					9
10	Activity Assistants	2,657	2,833	33,138	11.70	10
11	Social Service Workers	2,037	2,358	43,587	18.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,731	16,124	173,383	10.75	15
16	Dishwashers					16
17	Maintenance Workers	1,830	2,125	39,050	18.38	17
18	Housekeepers	11,148	12,099	114,901	9.50	18
19	Laundry	1,565	1,626	14,224	8.75	19
20	Administrator	2,656	2,708	107,892	39.84	20
21	Assistant Administrator	1,473	1,625	34,145	21.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,345	124,882	\$ 1,952,493 *	\$ 15.63	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 10,783	1,3	35
36	Medical Director		22,750	9,3	36
37	Medical Records Consultant		1,620	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,508	10,3	39
40	Physical Therapy Consultant		247	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,383	11,3	44
45	Social Service Consultant		2,978	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,269		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

0048181

Report Period Beginning:

1/1/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

Helia HC of Champaign

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Araceli Henson		Administrator	0	\$ 107,892	Workers' Compensation Insurance		\$ 92,953	IDPH License Fee		\$ 1,990		
Brenda Dively		Asst. Administrator	0	34,145	Unemployment Compensation Insurance		104,716	Advertising: Employee Recruitment		3,700		
					FICA Taxes		147,581	Health Care Worker Background Check				
					Employee Health Insurance		29,870	(Indicate # of checks performed)		1,845		
					Employee Meals			Patient Background Checks				
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		2,535		
					401(k) Match		3,718	Late Fees		1,333		
					Employee Benefits		5,307	Miscellaneous Licenses & Fees		1,130		
					Uniforms		125	Related Party Allocation-Bridgemark		447		
					Employee Insurance		4,608	Advertising		13,452		
					Related Party Allocation-Bridgemark		37,943	Less: Public Relations Expense (				
								Non-allowable advertising		(13,452)		
								Yellow page advertising (				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 142,037	TOTAL (agree to Schedule V, line 22, col.8)				\$ 426,821	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,980
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount		
Bridgemark Healthcare LLC-Management Fees			\$ 262,400	Section N/A			\$	Out-of-State Travel		\$		
								In-State Travel		178		
								Seminar Expense		344		
								Related Pary Allocation-Bridgemark		4,152		
								Entertainment Expense (				
								(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 262,400	TOTAL				\$	TOTAL		\$ 4,674
C. Professional Services												
Vendor/Payee		Type	Amount									
S.J. Schlosser & Company, LLC		Accounting Services	\$ 4,025									
Ceridian		Payroll Processing	12,309									
Much Shelist		Legal Fees	9,055									
Personnel Planners, Inc.		Unemployment Consultants	1,728									
Pitney Bowes		Postage	129									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 27,246								

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	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

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IHCA \$2,385
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5-10 Yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 33,719

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 341,533

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

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

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18)

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

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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