		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0048181

Facility Name: Helia Healthcare of Champaign

Address: 1915 S. Mattis Street (Number) Champaign (City) 61821 (Zip Code)

County: Champaign

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

HFS ID Number: 204019973001

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: Michael Parentin **Telephone Number:** (314) 431-0511

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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: 01/01/07 Ending: 12/31/07

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	21,801	2,511	3,402	27,714	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,801	2,511	3,402	27,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.35%

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 [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 5/1/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/06 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 2,332

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: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	148,691	17,774	6,565	173,030		173,030		173,030			1
2	Food Purchase		178,712		178,712	(6,074)	172,638	(162)	172,476			2
3	Housekeeping	88,734	19,042		107,776		107,776		107,776			3
4	Laundry	34,538	19,686		54,224		54,224		54,224			4
5	Heat and Other Utilities			105,455	105,455		105,455	(1,874)	103,581			5
6	Maintenance	34,267	15,267	36,698	86,232		86,232		86,232			6
7	Other (specify):*											7
8	TOTAL General Services	306,230	250,481	148,718	705,429	(6,074)	699,355	(2,036)	697,319			8
	B. Health Care and Programs											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	1,195,457	94,678	40,585	1,330,720		1,330,720	12,331	1,343,051			10
10a	Therapy											10a
11	Activities	33,297	1,200	4,989	39,486		39,486		39,486			11
12	Social Services	42,611	223		42,834		42,834		42,834			12
13	CNA Training											13
14	Program Transportation			404	404		404		404			14
15	Other (specify):*							2,793	2,793			15
16	TOTAL Health Care and Programs	1,271,365	96,101	64,478	1,431,944		1,431,944	15,124	1,447,068			16
	C. General Administration											
17	Administrative	65,419		196,305	261,724		261,724	(196,305)	65,419			17
18	Directors Fees											18
19	Professional Services			25,424	25,424		25,424	7,933	33,357			19
20	Dues, Fees, Subscriptions & Promotions			8,912	8,912		8,912	(6,743)	2,169			20
21	Clerical & General Office Expenses	35,714	9,477	216,220	261,411		261,411	(115,061)	146,350			21
22	Employee Benefits & Payroll Taxes			283,664	283,664	6,074	289,738		289,738			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,904	6,904		6,904	(3,374)	3,530			24
25	Other Admin. Staff Transportation			4,489	4,489		4,489	3,774	8,263			25
26	Insurance-Prop.Liab.Malpractice			70,434	70,434		70,434	826	71,260			26
27	Other (specify):*							15,952	15,952			27
28	TOTAL General Administration	101,133	9,477	812,352	922,962	6,074	929,036	(292,998)	636,038			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,678,728	356,059	1,025,548	3,060,336		3,060,336	(279,910)	2,780,426			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: 01/01/07 Ending: 12/31/07

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			5,993	5,993		5,993	(307)	5,686			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,714	12,714		12,714	(542)	12,172			32
33	Real Estate Taxes			43,440	43,440		43,440		43,440			33
34	Rent-Facility & Grounds			184,185	184,185		184,185	6,863	191,048			34
35	Rent-Equipment & Vehicles			4,115	4,115		4,115		4,115			35
36	Other (specify):*											36
37	TOTAL Ownership			250,447	250,447		250,447	6,014	256,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,492	415,200	570,692		570,692		570,692			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		155,492	479,805	635,297		635,297		635,297			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,678,728	511,551	1,755,801	3,946,080		3,946,080	(273,896)	3,672,184			45

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,874)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,890)	30		9
10	Interest and Other Investment Income	(564)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(162)	02		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	(52,275)	21		18
19	Entertainment	(3,551)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(142,426)	21		24
25	Fund Raising, Advertising and Promotional	(6,248)	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	(1,859)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (210,849)		$	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)	(63,046)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (63,046)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (273,895)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Champaign

ID# 0048181

Report Period Beginning: 01/01/07

Ending: 12/31/07

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts and Flowers	$ (635)	20	1
2	Bank Charges	(1,224)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	(1,859)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

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													1
2	Food Purchase	(162)											(162)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,874)											(1,874)	5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,036)											(2,036)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			12,331									12,331	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,793									2,793	15
16	**TOTAL Health Care and Programs**			15,124									15,124	16
	C. General Administration													
17	Administrative			(196,305)									(196,305)	17
18	Directors Fees													18
19	Professional Services			7,933									7,933	19
20	Fees, Subscriptions & Promotions	(6,883)		140									(6,743)	20
21	Clerical & General Office Expenses	(195,925)		80,864									(115,061)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,551)		177									(3,374)	24
25	Other Admin. Staff Transportation			3,774									3,774	25
26	Insurance-Prop.Liab.Malpractice			826									826	26
27	Other (specify):*			15,952									15,952	27
28	**TOTAL General Administration**	(206,359)		(86,639)									(292,998)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(208,395)		(71,515)									(279,910)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Helia Healthcare of Champaign **#** 0048181 **Report Period Beginning:** 01/01/07 **Ending:** 12/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,890)		1,583									(307)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(564)		22									(542)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			6,863									6,863	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(2,454)		8,468									6,014	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(210,849)		(63,047)									(273,896)	45

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100%	See Attached Listing		See Attached Listing		

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 [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* 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: 01/01/07 Ending: 12/31/07

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	10	Nursing & Med	$	Bridgemark Healthcare, LLC	100.00%	$ 12,331	$ 12,331	15
16	V	15	Other Nursing		Bridgemark Healthcare, LLC	100.00%	2,793	2,793	16
17	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	7,933	7,933	17
18	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	140	140	18
19	V	21	Clerical		Bridgemark Healthcare, LLC	100.00%	80,864	80,864	19
20	V	24	Seminars		Bridgemark Healthcare, LLC	100.00%	177	177	20
21	V	25	Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	3,774	3,774	21
22	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	826	826	22
23	V	27	Employee Benefits		Bridgemark Healthcare, LLC	100.00%	15,952	15,952	23
24	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,583	1,583	24
25	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	22	22	25
26	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	6,774	6,774	26
27	V	34	Rental - Storage Unit		Bridgemark Healthcare, LLC	100.00%	89	89	27
28	V								28
29	V								29
30	V	17	Management Fees	196,305	Bridgemark Healthcare, LLC	100.00%		(196,305)	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			$ 196,305			$ 133,258	$ * (63,047)	39

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

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	None								$		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	$		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: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Bridgemark Healthcare, LLC
Street Address: 11970 Borman Drive, Suite 250
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	10	Nursing & Med	Resident Days	244,055	9	$ 108,592	$ 108,592	27,714	$ 12,331	1
2	15	Other Nursing	Resident Days	244,055	9	24,600		27,714	2,793	2
3	19	Professional Fees	Resident Days	244,055	9	69,853		27,714	7,932	3
4	20	Dues, Subscriptions	Resident Days	244,055	9	1,232		27,714	140	4
5	21	Clerical	Resident Days	244,055	9	712,102	620,029	27,714	80,864	5
6	24	Seminars	Resident Days	244,055	9	1,558		27,714	177	6
7	25	Admin Staff Travel	Resident Days	244,055	9	33,238		27,714	3,774	7
8	26	Insurance	Resident Days	244,055	9	7,276		27,714	826	8
9	27	Employee Benefits	Resident Days	244,055	9	140,480		27,714	15,952	9
10	30	Depreciation	Resident Days	244,055	9	13,943		27,714	1,583	10
11	32	Interest	Resident Days	244,055	9	191		27,714	22	11
12	34	Rent	Resident Days	244,055	9	59,660		27,714	6,775	12
13	34	Rental - Storage Unit	Resident Days	244,055	9	781		27,714	89	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,173,506	$ 728,621		$ 133,258	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Midwest Bank		X	Line of Credit		1/1/07					12,714	6
7	Allocate Bridgemark Healthcare		X								22	7
8												8
9	TOTAL Facility Related						$	$			$ 12,736	9
	B. Non-Facility Related*											
10	Interest Income		X								(563)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (563)	14
15	TOTALS (line 9+line14)						$	$			$ 12,173	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: 01/01/07 Ending: 12/31/07

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 2006 report.	$	28,960	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.)	$	40,884	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,924	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,516	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,440	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2002		8
	2003		9
	2004		10
	2005	42,067	11
	2006	40,884	12

Estimate based upon prior years

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 2006 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 2006.

	(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	$ 40,883.76	$ 40,883.76
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,883.76	$ 40,883.76

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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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: 01/01/07 Ending: 12/31/07

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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											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

*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: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$	$		$	$	$	37
38	Concrete	2006	2,907	291	20	145	(145)	388	38
39	Commercial Floor Covering	2006	5,183	518	20	259	(259)	605	39
40	2 Wall A/C Units	2006	935	187	20	47	(140)	249	40
41	2 Wall A/C Units	2006	952	190	20	48	(143)	254	41
42	2 Wall A/C Units	2006	941	188	20	47	(141)	251	42
43	A/C Unit - Home Depot	2006	519	104	20	26	(78)	139	43
44	Roofing - D & R Roofing	2007	20,600	1,717	20	1,030	(687)	1,717	44
45	Pipes in Mechanical Room	2007	8,346	70	20	417	348	70	45
46	Life Safety Detectors	2007	1,660	28	20	83	55	28	46
47	A/C Unit - Direct Supply	2007	1,015	118	20	51	(68)	118	47
48	A/C Unit - Direct Supply	2007	1,512	176	20	76	(101)	176	48
49	Lighted Exit Sign	2007	2,211	18	20	111	92	18	49
50	A/C Unit - Direct Supply	2007	512	9	20	26	17	9	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	Book Depreciation			481			(481)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 47,292	$ 4,095		$ 2,365	$ (1,731)	$ 4,021	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: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 11,901	$ 2,126	$ 1,775	$ (351)	10	$ 3,033	71
72	Current Year Purchases	13,402	1,112	1,304	192	10	1,112	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 25,303	$ 3,238	$ 3,079	$ (159)		$ 4,145	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bridgemark Allocation		2005	$ 896	$ 242	$ 242	$	5	$ 775	76
77										77
78										78
79										79
80	TOTALS			$ 896	$ 242	$ 242	$		$ 775	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)	$ 73,491	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,575	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,686	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,890)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,941	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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: 01/01/07 Ending: 12/31/07

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				1,784			5
6	Allocate Bridgemark				6,864			6
7	TOTAL		118		$ 191,048 **			7

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

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

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.	/2008	$
13.	/2009	$
14.	/2010	$

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: $ 4,115 Description: See Attached
(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			$	$	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: 01/01/07 Ending: 12/31/07

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 # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 183,095	$		$ 183,095	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			40,490			40,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			158,985	119		159,104	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				94,336		94,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					32,630	61,037		93,667	13
14	TOTAL			$		$ 415,200	$ 155,492		$ 570,692	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07 (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	$ 97,589	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	453,795		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	400		5
6	Prepaid Insurance	682		6
7	Other Prepaid Expenses	4,906		7
8	Accounts Receivable (owners or related parties)	902,315		8
9	Other(specify): See Attached Schedule	100,698		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,560,385	$	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	38,695		15
16	Equipment, at Historical Cost	25,974		16
17	Accumulated Depreciation (book methods)	(6,840)		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): See Attached Schedule	22,306		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 80,135	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,640,520	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 341,974	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,688		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,768		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,060		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,095,729		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,611,219	$	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)**	$ 1,611,219	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 29,301	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,640,520	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (87,621)	1
2	Restatements (describe):		2
3			3
4	**Bridgemark Management Services - Prior Year Adjust**	49,180	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (38,441)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	67,742	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)**	$ 67,742	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)**	$ 29,301	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: 01/01/07 Ending: 12/31/07

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	$ 3,670,938	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,670,938	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	253,795	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 253,795	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***	563	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 563	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare Bad Debt Settlement Income	88,526	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 88,526	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,013,822	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	705,429	31
32	Health Care	1,431,944	32
33	General Administration	922,962	33
	B. Capital Expense		
34	Ownership	250,447	34
	C. Ancillary Expense		
35	Special Cost Centers	570,692	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)***	$ 3,946,080	40
41	**Income before Income Taxes (line 30 minus line 40)****	67,742	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 67,742	43

* **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. 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: 01/01/07 Ending: 12/31/07

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	$ 84,793	$ 40.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,735	9,141	231,633	25.34	3
4	Licensed Practical Nurses	9,877	10,002	248,504	24.85	4
5	CNAs & Orderlies	46,254	46,681	556,975	11.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,234	2,378	26,527	11.16	9
10	Activity Assistants	935	935	6,770	7.24	10
11	Social Service Workers	2,202	2,282	42,611	18.68	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,220	17.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,687	7,944	80,298	10.11	15
16	Dishwashers	4,261	4,296	32,173	7.49	16
17	Maintenance Workers	2,120	2,328	34,267	14.72	17
18	Housekeepers	8,268	8,411	64,718	7.69	18
19	Laundry	4,008	4,120	34,538	8.38	19
20	Administrator	2,080	2,080	64,910	31.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	36,223	17.41	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	1,901	2,093	27,365	13.08	31
32	Other Health Ca MDS Coordinator	2,080	2,080	46,187	22.21	32
33	Other(specify) Envirionmental Su	2,080	2,080	24,015	11.55	33
34	TOTAL (lines 1 - 33)	110,959	113,088	$ 1,678,728 *	$ 14.84	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	Monthly	$ 6,565	01-03	35
36	Medical Director	Monthly	18,500	09-03	36
37	Medical Records Consultant	Monthly	2,113	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	525	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,989	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,692		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	482	$ 19,765	10-03	50
51	Licensed Practical Nurses	649	18,184	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,132	$ 37,949		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: 01/01/07 Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gary Coulter	Administrator	0.00	$ 65,419
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,419

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 196,305
TOTAL (agree to Schedule V, line 17, col. 3)	$ 196,305
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ceridian	Payroll Services	$ 8,890
Allen Lefkovitz	Legal	884
eHealth Solutions	Computer Services	3,518
Element 5, Inc	Computer Services	30
FR&R Healthcare Consulting	Accounting Services	7,700
Keane	Computer Services	1,500
LTC Solutions	Computer Services	1,335
Sachnoff and Weaver	Legal	309
Simplified Computers	Computer Services	359
Personnel Planners	Unemployment Services	900
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,424

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,648
Unemployment Compensation Insurance	32,124
FICA Taxes	128,062
Employee Health Insurance	38,366
Employee Meals	6,074
Illinois Municipal Retirement Fund (IMRF)*	
401(K) Match	2,464
TOTAL (agree to Schedule V, line 22, col.8)	$ 289,738

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,590
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	439
Advertising	6,248
Gifts & Promotions	635
Bridgemark Allocation - Dues	140
Less: Public Relations Expense	(6,248)
Non-allowable advertising	(635)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,169

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,353
Allocate Bridgemark	177
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,530

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Helia Healthcare of Champaign # 0048181 Report Period Beginning: 01/01/07 Ending: 12/31/07

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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	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:** 01/01/07 **Ending:** 12/31/07

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

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

(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?

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,848** 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.

(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. $ **6,074** 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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 1**
d. Have vehicle usage logs been maintained? **No**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(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.