

		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: 0046672

Facility Name: Helia Healthcare of Energy

Address: 210 East College Energy 62933
 Number City Zip Code

County: Williamson

Telephone Number: (618) 942-7014 **Fax #** (618) 942-7196

HFS ID Number: 200412069001

Date of Initial License for Current Owners: 02/01/04

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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) <u>Michael Parentin</u>	
	(Title) <u>Chief Financial Officer</u>	
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 Energy

0046672 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	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>96</u>	Skilled (SNF)	<u>96</u>	<u>35,040</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>63</u>	Intermediate/DD	<u>63</u>	<u>22,995</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>159</u>	TOTALS	<u>159</u>	<u>58,035</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,251</u>	<u>2,445</u>	<u>2,965</u>	<u>25,661</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>4,557</u>			<u>4,557</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,808</u>	<u>2,445</u>	<u>2,965</u>	<u>30,218</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.07%

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 12/01/03

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/01/03 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 96 and days of care provided 2,046

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 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	127,291	16,511	8,504	152,306		152,306	152,306			1
2	Food Purchase		146,652		146,652	(4,788)	141,864	141,713			2
3	Housekeeping	85,170	13,347		98,517		98,517	98,517			3
4	Laundry	12,869	33,900		46,769		46,769	48,007	1,238		4
5	Heat and Other Utilities			120,664	120,664		120,664	120,886	222		5
6	Maintenance	27,833	8,843	45,515	82,191		82,191	93,702	11,511		6
7	Other (specify):*										7
8	TOTAL General Services	253,163	219,253	174,683	647,099	(4,788)	642,311	655,131	12,820		8
	B. Health Care and Programs										
9	Medical Director			8,800	8,800		8,800	8,800			9
10	Nursing and Medical Records	1,081,201	56,923	1,365	1,139,489		1,139,489	1,152,934	13,445		10
10a	Therapy	9,920		1,224	11,144		11,144	11,144			10a
11	Activities	71,173	3,316	8,927	83,416		83,416	83,416			11
12	Social Services	39,440	797	1,583	41,820		41,820	41,820			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,046	3,046		15
16	TOTAL Health Care and Programs	1,201,734	61,036	21,899	1,284,669		1,284,669	1,301,160	16,491		16
	C. General Administration										
17	Administrative	67,149		170,941	238,090		238,090	67,149	(170,941)		17
18	Directors Fees										18
19	Professional Services			24,037	24,037		24,037	32,686	8,649		19
20	Dues, Fees, Subscriptions & Promotions			34,683	34,683		34,683	16,047	(18,636)		20
21	Clerical & General Office Expenses	45,313	14,049	148,498	207,860		207,860	169,529	(38,331)		21
22	Employee Benefits & Payroll Taxes			287,152	287,152	4,788	291,940	294,492	2,552		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,159	5,159		5,159	2,048	(3,111)		24
25	Other Admin. Staff Transportation			6,464	6,464		6,464	12,590	6,126		25
26	Insurance-Prop.Liab.Malpractice			63,814	63,814		63,814	65,091	1,277		26
27	Other (specify):*							17,394	17,394		27
28	TOTAL General Administration	112,462	14,049	740,748	867,259	4,788	872,047	677,026	(195,021)		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,567,359	294,338	937,330	2,799,027		2,799,027	2,633,317	(165,710)		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 Energy #0046672 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			11,425	11,425	11,425	834	12,259			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			29,738	29,738	29,738	(3,296)	26,442			32
33	Real Estate Taxes			48,000	48,000	48,000	4,728	52,728			33
34	Rent-Facility & Grounds			273,000	273,000	273,000	5,384	278,384			34
35	Rent-Equipment & Vehicles			5,902	5,902	5,902		5,902			35
36	Other (specify):*										36
37	TOTAL Ownership			368,065	368,065	368,065	7,650	375,715			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		85,183	325,644	410,827	410,827		410,827			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			87,053	87,053	87,053		87,053			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		85,183	412,697	497,880	497,880		497,880			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,567,359	379,521	1,718,092	3,664,972	3,664,972	(158,060)	3,506,912			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

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.)

		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				4
5	Telephone, TV & Radio in Resident Rooms	(8,789)	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	(2,431)	30		9
10	Interest and Other Investment Income	(3,676)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(151)	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	(300)	21		18
19	Entertainment	(3,304)	24		19
20	Contributions	(150)	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	(126,204)	21		24
25	Fund Raising, Advertising and Promotional	(10,596)	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	(12,253)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,854)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	9,794		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 9,794		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (158,060)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Energy

ID# 0046672

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bond House Income	\$ (2,100)	34	1
2	Late Fees	(4,451)	20	2
3	Bank Charges	(479)	21	3
4	Gifts and Flowers	(3,742)	20	4
5	Travel - Marketing	(1,481)	25	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	(12,253)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy

0046672

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	(151)											(151)	2
3	Housekeeping													3
4	Laundry				1,238								1,238	4
5	Heat and Other Utilities	(8,789)			9,011								222	5
6	Maintenance				11,511								11,511	6
7	Other (specify):*													7
8	TOTAL General Services	(8,940)			21,760								12,820	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			13,445									13,445	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,046									3,046	15
16	TOTAL Health Care and Programs			16,491									16,491	16
	C. General Administration													
17	Administrative			(170,941)									(170,941)	17
18	Directors Fees													18
19	Professional Services			8,649									8,649	19
20	Fees, Subscriptions & Promotions	(18,789)		153									(18,636)	20
21	Clerical & General Office Expenses	(127,133)		88,170	632								(38,331)	21
22	Employee Benefits & Payroll Taxes				2,552								2,552	22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,304)		193									(3,111)	24
25	Other Admin. Staff Transportation	(1,481)		4,115	3,492								6,126	25
26	Insurance-Prop.Liab.Malpractice			901	376								1,277	26
27	Other (specify):*			17,394									17,394	27
28	TOTAL General Administration	(150,707)		(51,366)	7,052								(195,021)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,647)		(34,875)	28,812								(165,710)	29

STATE OF ILLINOIS

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/07

Ending:

Summary B

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	(2,431)		1,726	1,539								834	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,676)		24	356								(3,296)	32
33	Real Estate Taxes				4,728								4,728	33
34	Rent-Facility & Grounds	(2,100)		7,484									5,384	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(8,207)		9,234	6,623								7,650	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)	(167,854)		(25,641)	35,435								(158,060)	45

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		See Attached		

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: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy# 0046672Report Period Beginning: 01/01/07Ending: 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. 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	10 Nursing & Med	\$	Bridgemark Healthcare, LLC	100.00%	\$ 13,445	\$ 13,445	15
16	V	15 Other Nursing		Bridgemark Healthcare, LLC	100.00%	3,046	3,046	16
17	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	8,649	8,649	17
18	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	153	153	18
19	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	88,170	88,170	19
20	V	24 Seminars		Bridgemark Healthcare, LLC	100.00%	193	193	20
21	V	25 Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	4,115	4,115	21
22	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	901	901	22
23	V	27 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	17,394	17,394	23
24	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,726	1,726	24
25	V	32 Interest		Bridgemark Healthcare, LLC	100.00%	24	24	25
26	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	7,387	7,387	26
27	V	34 Rental - Storage Unit		Bridgemark Healthcare, LLC	100.00%	97	97	27
28	V							28
29	V							29
30	V	17 Management Fees	170,941	Bridgemark Healthcare, LLC	100.00%		(170,941)	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		\$ 170,941			\$ 145,300	\$ * (25,641)	39

* 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	4 Laundry	\$ 19,536	Helia Healthcare Servcies	100.00%	\$ 20,774	\$ 1,238		15
16	V	5 Utilities		Helia Healthcare Servcies	100.00%	9,011	9,011		16
17	V	6 Repairs and Maintenance	3,000	Helia Healthcare Servcies	100.00%	14,511	11,511		17
18	V	21 Clerical		Helia Healthcare Servcies	100.00%	632	632		18
19	V	22 Employee Benefits		Helia Healthcare Servcies	100.00%	2,552	2,552		19
20	V	25 Admin Staff Travel		Helia Healthcare Servcies	100.00%	3,492	3,492		20
21	V	26 Insurance		Helia Healthcare Servcies	100.00%	376	376		21
22	V	30 Depreciation		Helia Healthcare Servcies	100.00%	1,539	1,539		22
23	V	32 Interest		Helia Healthcare Servcies	100.00%	356	356		23
24	V	33 Real Estate Taxes		Helia Healthcare Servcies	100.00%	4,728	4,728		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		\$ 22,536			\$ 57,971	\$ *	35,435	39

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 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 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	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing & Med	Resident Days	244,055	9	\$ 108,592	\$ 108,592	30,218	\$ 13,445	1
2	15	Other Nursing	Resident Days	244,055	9	24,600		30,218	3,046	2
3	19	Professional Fees	Resident Days	244,055	9	69,853		30,218	8,649	3
4	20	Dues, Subscriptions	Resident Days	244,055	9	1,232		30,218	153	4
5	21	Clerical	Resident Days	244,055	9	712,102	620,029	30,218	88,170	5
6	24	Seminars	Resident Days	244,055	9	1,558		30,218	193	6
7	25	Admin Staff Travel	Resident Days	244,055	9	33,238		30,218	4,115	7
8	26	Insurance	Resident Days	244,055	9	7,276		30,218	901	8
9	27	Employee Benefits	Resident Days	244,055	9	140,480		30,218	17,394	9
10	30	Depreciation	Resident Days	244,055	9	13,943		30,218	1,726	10
11	32	Interest	Resident Days	244,055	9	191		30,218	24	11
12	34	Rent	Resident Days	244,055	9	59,660		30,218	7,387	12
13	34	Rental - Storage Unit	Resident Days	244,055	9	781		30,218	97	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		\$ 145,300	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

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 NO

Name of Related Organization Helia Healthcare Services
 Street Address 308 N. Mcleansboro Street
 City / State / Zip Code Benton, IL 62812
 Phone Number (618) 435-3304
 Fax Number ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	4	Laundry	Revenue	102,812	4	\$ 94,774	\$ 22,536	\$ 20,774	1
2	5	Utilities	Revenue	102,812	4	41,109	22,536	9,011	2
3	6	Repairs and Maintenance	Revenue	102,812	4	66,200	56,287	14,511	3
4	21	Clerical	Revenue	102,812	4	2,881	22,536	632	4
5	22	Employee Benefits	Revenue	102,812	4	11,644	22,536	2,552	5
6	25	Admin Staff Travel	Revenue	102,812	4	15,933	22,536	3,492	6
7	26	Insurance	Revenue	102,812	4	1,716	22,536	376	7
8	30	Depreciation	Revenue	102,812	4	7,019	22,536	1,539	8
9	32	Interest	Revenue	102,812	4	1,624	22,536	356	9
10	33	Real Estate Taxes	Revenue	102,812	4	21,571	22,536	4,728	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	TOTALS					\$ 264,471	\$ 129,265	\$ 57,971	25

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	Midwest Bank		X	Line of Credit						29,738	6									
7	Allocate Helia Health Services		X							356	7									
8	Allocate Bridgemark Healthcare		X							24	8									
9	TOTAL Facility Related									\$ 30,118	9									
B. Non-Facility Related*																				
10	Interest Income		X							(3,676)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related									(3,676)	14									
15	TOTALS (line 9+line14)									\$ 26,442	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.)

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 Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-06-227-019</u>	<u>Long Term Care</u>	\$ <u>42,543.30</u>	\$ <u>42,543.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,543.30</u>	\$ <u>42,543.30</u>

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 Energy

0046672 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,850 B. General Construction Type: Exterior Brick Veneer Frame Masonry Brick 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).

House Adjacent to Facility - 206 East College (no assets or expenses are included for this building on the cost report)

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>Allocate Helia Healthcare Services</u>		<u>2006</u>	<u>\$ 1,096</u>	1
2					2
3	TOTALS			\$ 1,096	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

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		Helia Healthcare Services - Allocation	2006		\$ 6,532	\$ 327	20	\$ 327	\$	\$ 599	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Helia Healthcare Services - Allocation	2007		1,173	65	20	59	(6)	84	9
10											10
11		Direct Supply - "C" Wing Signs		2004	1,752	350	5	350	0	1,226	11
12		Southside Lumbar - Handrail Molding		2004	1,000	200	5	200	(0)	700	12
13		Wallpaper		2004	1,740	348	5	348	(0)	1,160	13
14		Wallpaper		2004	1,062	212	5	212	(0)	691	14
15		Room Signs		2004	1,357	136	10	136		611	15
16		Paint Border		2004	2,253	225	10	225		1,014	16
17		Door Handles And Knobs		2004	729	73	10	73		328	17
18		Border For B Wing		2004	582	58	10	58		262	18
19		Wallpaper for C Wing		2004	1,107	111	10	111		498	19
20		Handrails, Brackets		2004	1,093	109	10	109		492	20
21		Wire Smoke Detectors		2004	572	57	10	57		257	21
22		Door Knobs B & C Wings		2004	766	77	10	77		345	22
23		Direct Supply 2 Wall A/C Units		2005	1,035	207	20	52	(155)	259	23
24		Getswon - Roof		2006	11,100	1,110	20	555	(555)	1,480	24
25		Various - Roof		2006	2,657	266	20	133	(133)	354	25
26		Direct Supply Wall Air Conditioner		2006	1,143	229	20	57	(172)	438	26
27		Home Depot Smoke Detectors		2006	749	150	20	37	(112)	287	27
28		Direct Supply - 2 A/C Units		2006	1,055	211	20	53	(158)	334	28
29		Home Depot - Fence		2006	573	115	20	29	(86)	172	29
30		Direct Supply 2 Wall A/C Units		2006	1,044	209	20	52	(157)	313	30
31		Marion Glass - Glass door and Install		2007	1,210	121	10	121	(0)	121	31
32		Various - Roof Gestwon, Associated, etc)		2007	17,623	1,467	10	1,762	296	1,469	32
33		Baker and Sons - 80 gallon water heater		2007	2,829	47	10	283	236	47	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 62,736	\$ 6,479		\$ 5,477	\$ (1,003)	\$ 13,541	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 Energy # 0046672 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	\$ 28,560	\$ 6,665	\$ 3,977	\$ (2,688)	10	\$ 7,849	71
72	Current Year Purchases	18,513	1,281	2,541	1,260	10	3,176	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 47,073	\$ 7,946	\$ 6,518	\$ (1,428)		\$ 11,025	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	\$ 976	\$ 264	\$ 264	\$	5	\$ 845	76
77										77
78										78
79										79
80	TOTALS			\$ 976	\$ 264	\$ 264	\$		\$ 845	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)	\$ 111,881	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,689	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,259	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,431)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 25,411	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.

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:				\$ <u>273,000</u>			3
4	Additions							4
5	<u>Allocate Bridgemark</u>				<u>7,484</u>			5
6	<u>Bond House Rental Income</u>				<u>(2,100)</u>			6
7	TOTAL				\$ <u>278,384</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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: _____ *

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: \$ 5,902 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

	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	39-03	hrs	\$		\$ 134,565	\$		\$ 134,565	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			25,630			25,630	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			155,566	225		155,791	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 prescripts				61,464		61,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					9,883	23,494		33,377	13
14	TOTAL			\$		\$ 325,644	\$ 85,183		\$ 410,827	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 Energy# 0046672Report 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	\$ 34,455	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	802,862		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,444		5
6	Prepaid Insurance	1,051		6
7	Other Prepaid Expenses	1,843		7
8	Accounts Receivable (owners or related parties)	264,541		8
9	Other(specify): <u>See Attached Schedule</u>	88,234		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,194,430	\$	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	35,419		15
16	Equipment, at Historical Cost	39,881		16
17	Accumulated Depreciation (book methods)	(22,778)		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)	\$ 52,522	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,246,952	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 330,788	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,090		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,936		31
32	Accrued Real Estate Taxes(Sch.IX-B)	144,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,705,680		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,264,294	\$	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)	\$ 2,264,294	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,017,342)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,246,952	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (887,526)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(8)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (887,534)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(129,808)	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)	\$ (129,808)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,017,342)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy# 0046672Report Period Beginning: 01/01/07Ending: 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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,227,629	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,227,629	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	222,555	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 222,555	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***	3,676	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,676	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bond House Income	2,100	28
28a	Medicare Bad Debt Settlement Income	79,204	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 81,304	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,535,164	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	647,099	31
32	Health Care	1,284,669	32
33	General Administration	867,259	33
B. Capital Expense			
34	Ownership	368,065	34
C. Ancillary Expense			
35	Special Cost Centers	410,827	35
36	Provider Participation Fee	87,053	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,664,972	40
41	Income before Income Taxes (line 30 minus line 40)**	(129,808)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (129,808)	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 Energy

0046672

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,139	1,155	\$ 26,443	\$ 22.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,512	4,618	96,459	20.89	3
4	Licensed Practical Nurses	18,451	19,179	322,137	16.80	4
5	CNAs & Orderlies	43,387	44,429	392,526	8.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	744	920	9,920	10.78	8
9	Activity Director					9
10	Activity Assistants	6,140	6,302	71,173	11.29	10
11	Social Service Workers	2,720	2,880	39,440	13.70	11
12	Dietician					12
13	Food Service Supervisor	2,142	2,142	30,475	14.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,616	11,992	96,816	8.07	15
16	Dishwashers					16
17	Maintenance Workers	2,065	2,158	27,833	12.90	17
18	Housekeepers	11,009	11,314	85,170	7.53	18
19	Laundry	1,220	1,480	12,869	8.69	19
20	Administrator	2,080	2,080	67,149	32.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	32,501	15.63	23
24	Clerical	884	944	12,812	13.57	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)	16,375	17,275	150,904	8.74	30
31	Medical Records	2,019	2,136	28,648	13.41	31
32	Other Health Care MDS Coordinator	1,958	2,058	30,978	15.05	32
33	Other(specify) Care Plan Nurse	1,871	1,894	33,105	17.48	33
34	TOTAL (lines 1 - 33)	132,334	137,038	\$ 1,567,360 *	\$ 11.44	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	202	\$ 8,504	01-03	35
36	Medical Director	Monthly	8,800	09-03	36
37	Medical Records Consultant	Quarterly	1,200	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		165	10-03	39
40	Physical Therapy Consultant		1,224	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	159	8,927	11-03	44
45	Social Service Consultant	17	948	12-03	45
46	Other(specify)				46
47	Psych Consultant	Monthly	635	12-03	47
48					48
49	TOTAL (lines 35 - 48)	378	\$ 30,403		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	
Christopher Haake	Administrator	0.00	\$ 67,149	Workers' Compensation Insurance	\$ 81,699	IDPH License Fee	\$	
				Unemployment Compensation Insurance	41,540	Advertising: Employee Recruitment	12,810	
				FICA Taxes	122,454	Health Care Worker Background Check	2,864	
				Employee Health Insurance	43,321	(Indicate # of checks performed)		
				Employee Meals	4,788	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Gifts and Flowers	3,742	
				401(K) Match	690	Advertising	10,596	
						Dues and Subscriptions	220	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 67,149			Allocate Bridgemark Healthcare	153	
(List each licensed administrator separately.)						Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(14,338)	
						Yellow page advertising	()	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
Bridgemark Healthcare, LLC			\$ 170,941				\$ 16,047	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 170,941	TOTAL (agree to Schedule V, line 22, col.8)				
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ceridian	Payroll Processing		\$ 7,653				Out-of-State Travel	\$
eHealth Data Solutions	Computer Services		3,285					
FR&R Healthcare Consulting	Accounting		5,450					
Heartland Computer Consulting	Computer Services		253				In-State Travel	
Keane	Computer Services		1,388					
Mark Collins	Computer Services		118					
MDI Technologies	Computer Services		2,848					
Sachnoff and Weaver	Legal		1,797				Seminar Expense	1,855
Personnel Planners	Unemployment Consultant		1,245				Allocate Bridgemark	193
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,037				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,048

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Helia Healthcare of Energy

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 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 Energy

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. \$ 6,395 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. \$ 87,053
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? N/A
- (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. \$ 4,788 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? 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. \$ _____
- (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 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