

Facility Name & ID Number Helia Healthcare of Energy

0046672 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>35,136</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>63</u>	Intermediate/DD	<u>63</u>	<u>23,058</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>159</u>	TOTALS	<u>159</u>	<u>58,194</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>21,960</u>	<u>2,441</u>	<u>3,256</u>	<u>27,657</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>4,250</u>			<u>4,250</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,210</u>	<u>2,441</u>	<u>3,256</u>	<u>31,907</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.83%

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 55 and days of care provided 2,946

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	136,744	19,172	8,964	164,880		164,880		164,880		1
2	Food Purchase		162,733		162,733		162,733	(69)	162,664		2
3	Housekeeping	79,553	15,796		95,349		95,349		95,349		3
4	Laundry	12,308	8,391	51,051	71,750		71,750	11,361	83,111		4
5	Heat and Other Utilities			103,035	103,035		103,035	16,415	119,450		5
6	Maintenance	29,181	11,779	31,822	72,782		72,782	2,632	75,414		6
7	Other (specify):*										7
8	TOTAL General Services	257,786	217,871	194,872	670,529		670,529	30,339	700,868		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,151,366	66,771	1,499	1,219,636		1,219,636	18,563	1,238,199		10
10a	Therapy			185,559	185,559		185,559		185,559		10a
11	Activities	56,350	9,518	1,906	67,774		67,774		67,774		11
12	Social Services	55,305	576	4,542	60,423		60,423		60,423		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,263,021	76,865	203,106	1,542,992		1,542,992	18,563	1,561,555		16
	C. General Administration										
17	Administrative	70,950		181,847	252,797		252,797	(156,899)	95,898		17
18	Directors Fees										18
19	Professional Services			31,083	31,083		31,083	4,966	36,049		19
20	Dues, Fees, Subscriptions & Promotions			34,686	34,686		34,686	(14,204)	20,482		20
21	Clerical & General Office Expenses	37,749	17,724	62,534	118,007		118,007	106,112	224,119		21
22	Employee Benefits & Payroll Taxes			268,077	268,077		268,077	35,570	303,647		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,023	1,023		1,023	705	1,728		24
25	Other Admin. Staff Transportation			10,470	10,470		10,470	25,844	36,314		25
26	Insurance-Prop.Liab.Malpractice			104,877	104,877		104,877	2,236	107,113		26
27	Other (specify):*										27
28	TOTAL General Administration	108,699	17,724	694,597	821,020		821,020	4,330	825,350		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,629,506	312,460	1,092,575	3,034,541		3,034,541	53,232	3,087,773		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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			13,181	13,181	13,181	8,624	21,805			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			30,816	30,816	30,816	1,469	32,285			32
33	Real Estate Taxes			35,617	35,617	35,617	4,947	40,564			33
34	Rent-Facility & Grounds			301,600	301,600	301,600	7,090	308,690			34
35	Rent-Equipment & Vehicles			13,472	13,472	13,472	329	13,801			35
36	Other (specify):*										36
37	TOTAL Ownership			394,686	394,686	394,686	22,459	417,145			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		105,439	54,645	160,084	160,084		160,084			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			87,292	87,292	87,292		87,292			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		105,439	141,937	247,376	247,376		247,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,629,506	417,899	1,629,198	3,676,603	3,676,603	75,691	3,752,294			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: 01/01/08

Ending: 12/31/08

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	(6,865)	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	846	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	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	(16,755)	21		18
19	Entertainment	(3,727)	21		19
20	Contributions	(335)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,885)	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	(8,416)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,206)		\$	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)	119,897		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 119,897		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 75,691		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Energy

ID# 0046672

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bond House Income	\$ (2,317)	34	1
2	Gifts and Flowers	(6,099)	20	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	(8,416)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(69)	0	0	0	0	0	0	0	0	0	0	(69)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	11,361	0	0	0	0	0	0	0	0	11,361	4
5	Heat and Other Utilities	(6,865)	97	23,183	0	0	0	0	0	0	0	0	16,415	5
6	Maintenance	0	0	2,632	0	0	0	0	0	0	0	0	2,632	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,934)	97	37,176	0	30,339	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	18,563	0	0	0	0	0	0	0	0	0	18,563	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	18,563	0	0	0	0	0	0	0	0	0	18,563	16
	C. General Administration													
17	Administrative	0	(156,899)	0	0	0	0	0	0	0	0	0	(156,899)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,995	971	0	0	0	0	0	0	0	0	4,966	19
20	Fees, Subscriptions & Promotions	(14,984)	562	218	0	0	0	0	0	0	0	0	(14,204)	20
21	Clerical & General Office Expenses	(20,817)	107,061	19,868	0	0	0	0	0	0	0	0	106,112	21
22	Employee Benefits & Payroll Taxes	0	25,359	10,211	0	0	0	0	0	0	0	0	35,570	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	636	69	0	0	0	0	0	0	0	0	705	24
25	Other Admin. Staff Transportation	0	12,811	13,033	0	0	0	0	0	0	0	0	25,844	25
26	Insurance-Prop.Liab.Malpractice	0	1,614	622	0	0	0	0	0	0	0	0	2,236	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(35,801)	(4,861)	44,992	0	4,330	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,735)	13,799	82,168	0	53,232	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	846	1,723	6,055	0	0	0	0	0	0	0	0	8,624	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,469	0	0	0	0	0	0	0	0	1,469	32
33	Real Estate Taxes	0	0	4,947	0	0	0	0	0	0	0	0	4,947	33
34	Rent-Facility & Grounds	(2,317)	9,407	0	0	0	0	0	0	0	0	0	7,090	34
35	Rent-Equipment & Vehicles	0	329	0	0	0	0	0	0	0	0	0	329	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,471)	11,459	12,471	0	22,459	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(44,206)	25,258	94,639	0	75,691	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		Bridgemark Healthcare	St. Louis	Management Co
				Helia Healthcare Services	Benton	Laundry, Maint. Ser
				Bridgemark Employer Services	St. Louis	Human Resources
				Bridgemark Medical Supply	St. Louis	Medical Supplies

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing & Medical Records	\$	Bridgemark Healthcare, LLC	100.00%	\$ 18,563	\$ 18,563	1
2	V	17 Management Fees	181,847	Bridgemark Healthcare, LLC	100.00%	24,948	(156,899)	2
3	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	3,995	3,995	3
4	V	20 Dues, Fees, & Subscriptions		Bridgemark Healthcare, LLC	100.00%	562	562	4
5	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	107,061	107,061	5
6	V	22 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	25,359	25,359	6
7	V	24 Seminars		Bridgemark Healthcare, LLC	100.00%	636	636	7
8	V	25 Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	12,811	12,811	8
9	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,614	1,614	9
10	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,723	1,723	10
11	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	329	329	11
12	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	9,407	9,407	12
13	V	5 Utilities		Bridgemark Healthcare, LLC	100.00%	97	97	13
14	Total		\$ 181,847			\$ 207,105	\$ * 25,258	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 Energy# 0046672Report Period Beginning: 01/01/08Ending: 12/31/08

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	\$ 51,051	Helia Healthcare Services	100.00%	\$ 62,412	\$ 11,361	15	
16	V	5 Utilities		Helia Healthcare Services	100.00%	23,183	23,183	16	
17	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	5,632	2,632	17	
18	V	19 Professional Services		Helia Healthcare Services	100.00%	971	971	18	
19	V	21 Clerical & Office Supplies		Helia Healthcare Services	100.00%	19,868	19,868	19	
20	V	22 Payroll Taxes & Employee Benefits		Helia Healthcare Services	100.00%	10,211	10,211	20	
21	V	24 Travel & Seminar		Helia Healthcare Services	100.00%	69	69	21	
22	V	25 Other Admin Transportation		Helia Healthcare Services	100.00%	13,033	13,033	22	
23	V	26 Insurance		Helia Healthcare Services	100.00%	622	622	23	
24	V	30 Depreciation		Helia Healthcare Services	100.00%	6,055	6,055	24	
25	V	32 Interest		Helia Healthcare Services	100.00%	1,469	1,469	25	
26	V	33 Real Estate Taxes		Helia Healthcare Services	100.00%	4,947	4,947	26	
27	V	20 Dues, Fees, & Subscriptions		Helia Healthcare Services	100.00%	218	218	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		\$ 54,051			\$ 148,690	\$ *	94,639	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100%	179,849	7	12.20	Distribution	\$ 24,948	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,948		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: 01/01/08

Ending: 12/31/08

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 100
 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 & Medical Records	Resident Days	261,924	10	\$ 152,384	\$ 152,384	31,907	\$ 18,563	1
2	17	Owners Compensation	Resident Days	261,924	10	204,797		31,907	24,948	2
3	19	Professional Fees	Resident Days	261,924	10	32,797		31,907	3,995	3
4	20	Dues, Subscriptions	Resident Days	261,924	10	4,612		31,907	562	4
5	21	Clerical	Resident Days	261,924	10	878,862	815,418	31,907	107,061	5
6	22	Employee Benefits	Resident Days	261,924	10	208,169		31,907	25,359	6
7	24	Seminars	Resident Days	261,924	10	5,223		31,907	636	7
8	25	Admin Staff Travel	Resident Days	261,924	10	105,166		31,907	12,811	8
9	26	Insurance	Resident Days	261,924	10	13,246		31,907	1,614	9
10	30	Depreciation	Resident Days	261,924	10	14,145		31,907	1,723	10
11	35	Equipment Rental	Resident Days	261,924	10	2,700		31,907	329	11
12	34	Rent	Resident Days	261,924	10	77,223		31,907	9,407	12
13	5	Utilities	Resident Days	261,924	10	797		31,907	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					\$ 1,700,121	\$ 967,802		\$ 207,105	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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	137,437	4	\$ 158,696	\$ 115,204	54,051	\$ 62,412	1
2	5	Utilities	Revenue	137,437	4	58,949	54,051	54,051	23,183	2
3	6	Maintenance	Revenue	137,437	4	14,320	10,640	54,051	5,632	3
4	19	Professional Services	Revenue	137,437	4	2,470	54,051	54,051	971	4
5	21	Clerical & Office Supplies	Revenue	137,437	4	50,519	46,312	54,051	19,868	5
6	22	Payroll Taxes & Emp. Ben.	Revenue	137,437	4	25,964	54,051	54,051	10,211	6
7	24	Travel & Seminar	Revenue	137,437	4	176	54,051	54,051	69	7
8	25	Other Admin Transp	Revenue	137,437	4	33,140	54,051	54,051	13,033	8
9	26	Insurance	Revenue	137,437	4	1,582	54,051	54,051	622	9
10	30	Depreciation	Revenue	137,437	4	15,395	54,051	54,051	6,055	10
11	32	Interest	Revenue	137,437	4	3,736	54,051	54,051	1,469	11
12	33	Real Estate Taxes	Revenue	137,437	4	12,579	54,051	54,051	4,947	12
13	20	Dues, Fees, & Subscriptions	Revenue	137,437	4	554	54,051	54,051	218	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					\$ 378,080	\$ 172,156		\$ 148,690	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		1/1/07				30,816	6									
7	Related Party Alloc. - Helia Health									1,469	7									
8											8									
9	TOTAL Facility Related									\$ 32,285	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related									\$	14									
15	TOTALS (line 9+line14)									\$ 32,285	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.)

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	62,371	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.)			\$	97,988	2
3. Under or (over) accrual (line 2 minus line 1).			\$	35,617	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	35,617	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2003	<u>50,153</u>	<u>8</u>			
2004	<u>41,697</u>	<u>9</u>			
2005	<u>42,189</u>	<u>10</u>			
2006	<u>42,543</u>	<u>11</u>			
2007	<u>35,617</u>	<u>12</u>			
<u>Line 4 - Estimated 2008 Real Estate Taxes are paid in advance to the lessor. Therefore there is no accrual.</u>					
<u>Line 7 - 35,617</u>					
<u>Helia Healthcare Allocation - 4,947</u>					
<u>Schedule V line 33 - 40,564</u>					
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>35,616.86</u>	\$ <u>35,616.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>35,616.86</u>	\$ <u>35,616.86</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08 Ending:

12/31/08

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>Related Party Allocation - Helia Healthcare</u>			\$ <u>7,691</u>	1
2					2
3	TOTALS			\$ 7,691	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		Related Party Allocation - Helia Healthcare	2006		\$ 63,280	\$	25	\$ 2,460	\$ 2,460	\$ 3,535	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Related Party Allocation - Helia Healthcare									9
10		Water & Sewer Pipe Installation	2006		748		20	38	38	90	10
11		Plumbing & Heating Installation	2006		895		20	45	45	108	11
12		A/C Unit - 4 Ton	2007		2,155		10	216	216	359	12
13		"C" Wing Signs	2004		1,752	350	5	350		1,577	13
14		Handrail Molding	2004		1,000	200	5	200		900	14
15		Wallpaper	2004		1,740	348	5	348		1,508	15
16		Wallpaper	2004		1,062	212	5	212		903	16
17		Room Signs	2004		1,357		10	136	136	680	17
18		Paint Border	2004		2,253		10	225	225	1,125	18
19		Door Handles and Knobs	2004		729		10	73	73	365	19
20		Border for B Wing	2004		582		10	58	58	290	20
21		Wallpaper for C Wing	2004		1,107		10	111	111	555	21
22		Handrails, Brackets	2004		1,093		10	109	109	545	22
23		Wire Smoke Detectors	2004		572		10	57	57	285	23
24		Door Knobs B & C Wings	2004		766		10	77	77	385	24
25		2 Wall A/C Units	2005		1,035	207	5	207		466	25
26		Roof	2006		13,757	1,376	10	1,376		3,210	26
27											27
28		Wall Air Conditioner	2006		1,143	229	5	229		667	28
29		Smoke Detectors	2006		749	150	5	150		437	29
30		2 A/C Units	2006		1,055	211	5	211		545	30
31		Fence	2006		573	115	5	115		287	31
32		2 Wall A/C Units	2006		1,044	209	5	209		522	32
33		Glass Door and Install	2007		1,210	121	10	121		242	33
34		Roof	2007		17,623	1,762	10	1,762		3,231	34
35		80 Gallon Water Heater	2007		2,829	283	10	283		330	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	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	Trailor for Resident smokers	2008	\$ 1,295	\$ 119	10	\$ 119	\$	\$ 119	37
38	Doors	2008	1,716	95	15	95		95	38
39	Doors	2008	6,837	266	15	266		266	39
40	Wall Air Conditioner	2008	3,040	506	5	506		507	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)		\$ 134,997	\$ 6,759		\$ 10,364	\$ 3,605	\$ 24,134	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: 01/01/08 Ending: 12/31/08

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	\$ 49,029	\$ 6,385	\$ 10,357	\$ 3,972	3-5	\$ 26,876	71
72	Current Year Purchases	3,705	37	434	397	5	434	72
73	Fully Depreciated Assets	2,114					2,114	73
74								74
75	TOTALS	\$ 54,848	\$ 6,422	\$ 10,791	\$ 4,369		\$ 29,424	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 Healthcare Allocation		2005	\$ 2,062	\$	\$ 240	\$ 240	5	\$ 1,071	76
77	Helia Healthcare Allocation		2006	2,050		410	410	5	1,063	77
78										78
79										79
80	TOTALS			\$ 4,112	\$	\$ 650	\$ 650		\$ 2,134	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)	\$ 201,648	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,181	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,805	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,624	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 55,692	85

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

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

G. Construction-in-Progress

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

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

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

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>301,600</u>			3
4	Additions							4
5	<u>Related Party Allocation - Bridgemark</u>				<u>9,407</u>			5
6	<u>Bond House Rental Income</u>				<u>(2,317)</u>			6
7	TOTAL				\$ <u>308,690</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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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: \$ 13,801 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	<u>Section N/A</u>		\$ _____	\$ _____	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	10a-03	hrs	\$		\$ 83,648	\$		\$ 83,648	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			14,185			14,185	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			87,726			87,726	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				90,744		90,744	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound Care/Oxygen</u>	39-02					14,695		14,695	12
13	Other (specify): <u>Lab/X-Ray/Other</u>	39-03				54,645			54,645	13
14	TOTAL			\$		\$ 240,204	\$ 105,439		\$ 345,643	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: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,990	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>38,173</u>)	936,358		3
4	Supply Inventory (priced at)	2,496		4
5	Short-Term Investments			5
6	Prepaid Insurance	275		6
7	Other Prepaid Expenses	1,314		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposit</u>	181		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 947,614	\$	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	45,267		15
16	Equipment, at Historical Cost	43,655		16
17	Accumulated Depreciation (book methods)	(35,959)		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)	\$ 52,963	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,000,577	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 288,146	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,560		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,678		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Bridgemark Healthcare</u>	480,438		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 871,822	\$	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	<u>Note Payable - Owner</u>	203,342		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 203,342	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,075,164	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (74,587)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,000,577	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,017,342)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,017,342)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(122,174)	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) <u>Settlement with Lessor</u>	1,064,929	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 942,755	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)	\$ (74,587)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 3,505,342	1
2	Discounts and Allowances for all Levels	(51,169)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,454,173	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,939	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 97,939	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Bond House Rent</u>	2,317	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,317	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,554,429	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	670,529	31
32	Health Care	1,542,992	32
33	General Administration	821,020	33
B. Capital Expense			
34	Ownership	394,686	34
C. Ancillary Expense			
35	Special Cost Centers	160,084	35
36	Provider Participation Fee	87,292	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,676,603	40
41	Income before Income Taxes (line 30 minus line 40)**	(122,174)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (122,174)	43

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

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

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

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

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning: 01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,035	\$ 46,863	\$ 23.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,034	6,308	126,174	20.00	3
4	Licensed Practical Nurses	16,703	17,768	316,424	17.81	4
5	CNAs & Orderlies	42,217	45,144	423,898	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,250	4,430	56,350	12.72	10
11	Social Service Workers	3,583	3,687	55,305	15.00	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,866	14.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,100	12,700	105,878	8.34	15
16	Dishwashers					16
17	Maintenance Workers	1,933	2,085	29,181	14.00	17
18	Housekeepers	8,646	9,231	79,553	8.62	18
19	Laundry	1,531	1,642	12,308	7.50	19
20	Administrator	2,080	2,080	70,950	34.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,172	2,320	37,749	16.27	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,978	2,061	28,347	13.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	14,494	15,766	142,278	9.02	30
31	Medical Records	1,721	1,906	28,236	14.81	31
32	Other Health Care MDS Coordinator	2,143	2,175	39,146	18.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,665	133,418	\$ 1,629,506 *	\$ 12.21	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	213	\$ 8,964	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant	Quarterly	720	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		779	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	34	1,906	11-03	44
45	Social Service Consultant	64	3,607	12-03	45
46	Other(specify)				46
47	Psych Consultant	Monthly	935	12-03	47
48					48
49	TOTAL (lines 35 - 48)	311	\$ 26,511		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	
Chris Haake	Administrator	0	\$ 70,950	Workers' Compensation Insurance	\$ 64,269	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	38,597	Advertising: Employee Recruitment	7,487	
				FICA Taxes	124,657	Health Care Worker Background Check	1,792	
				Employee Health Insurance	38,910	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,028	
				401(k) Match	1,644	Licenses & Fees	705	
						Late Fees	2,695	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 70,950	Related Party Allocation - Bridgemark	25,359	Related Party Allocation - Bridgemark	562	
(List each licensed administrator separately.)				Related Party Allocation - Helia Health	10,211	Related Party Allocation - Helia Health	218	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Bridgemark Healthcare LLC - Management Fees			\$ 181,847					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 181,847	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description			Description	
C. Professional Services				Line #			Amount	
Vendor/Payee	Type	Amount		Amount			Amount	
Kramer & Frank	Legal	\$ 35		Section N/A			Out-of-State Travel	
Craig & Craig	Legal	478						
Sachnoff & Weaver	Legal	6,424					In-State Travel	
Reed Smith	Legal	6,348						
Donovan Rose Nester	Legal	8,758					Seminar Expense	
FR&R Healthcare Consulting, Inc.	Accounting Services	382					1,023	
Ceridian	Payroll Services	8,658					Related Party Allocation - Bridgemark	
							636	
							Related Party Allocation - Helia Health	
							69	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 31,083				(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 1,728	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Helia Healthcare of Energy

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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

Helia Healthcare of Energy
Attachment to Schedule VII A
Related Nursing Homes
12/31/2008

Helia Healthcare of Belleville
Helia Healthcare of Benton
Helia Healthcare of Carbondale
Helia Healthcare of Champaign
Helia Healthcare of Urbana
Helia Healthcare of Greenville
Frankfort Healthcare & Rehab Center
Helia Southbelt Healthcare
Sangamon Care Center

Helia Healthcare of Energy
Attachment to Schedule XII B
Equipment Rentals
12/31/2008

Description			
16A	Dish Machine	\$	1,174
16B	Copier Rental		5,037
16C	Related Party Allocation - Bridgemark		329
16D	Nursing Rental Equipment		7,261
		<u>\$</u>	<u>13,801</u>