

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0046672</u></p> <p>Facility Name: <u>Helia Healthcare of Energy</u></p> <p>Address: <u>210 East College</u> <u>Energy</u> <u>62933</u> Number City Zip Code</p> <p>County: <u>Williamson</u></p> <p>Telephone Number: <u>(618) 942-7014</u> Fax # <u>(618) 942-7196</u></p> <p>HFS ID Number: <u>200412069001</u></p> <p>Date of Initial License for Current Owners: <u>02/01/04</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Michael Parentin</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td rowspan="3" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>See Accountant's Compilation Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Cindy A. Tefteller</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, LLC</u> <u>233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Michael Parentin</u> (Date) _____		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u>	(Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u>		(Firm Name & Address) <u>C.J. Schlosser & Company, LLC</u> <u>233 East Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	21,245	2,120	2,105	25,470	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD			3,643	3,643	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,245	2,120	5,748	29,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.16%

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 2,105

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	126,588	17,947	7,281	151,816		151,816		151,816		1
2	Food Purchase		160,310		160,310		160,310	(58)	160,252		2
3	Housekeeping	72,906	17,765		90,671		90,671		90,671		3
4	Laundry	11,209	9,649	46,609	67,467		67,467	16,320	83,787		4
5	Heat and Other Utilities			105,220	105,220		105,220	7,907	113,127		5
6	Maintenance	29,224	7,555	45,525	82,304		82,304	(433)	81,871		6
7	Other (specify):*										7
8	TOTAL General Services	239,927	213,226	204,635	657,788		657,788	23,736	681,524		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,019,082	50,438	4,584	1,074,104		1,074,104	20,323	1,094,427		10
10a	Therapy			187,046	187,046		187,046		187,046		10a
11	Activities	49,069	16,720	4,636	70,425		70,425	(1,361)	69,064		11
12	Social Services	47,570	606	2,615	50,791		50,791		50,791		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,115,721	67,764	208,481	1,391,966		1,391,966	18,962	1,410,928		16
	C. General Administration										
17	Administrative	73,667		164,177	237,844		237,844	(112,988)	124,856		17
18	Directors Fees										18
19	Professional Services			15,453	15,453		15,453	6,757	22,210		19
20	Dues, Fees, Subscriptions & Promotions			36,877	36,877		36,877	(16,581)	20,296		20
21	Clerical & General Office Expenses	35,565	19,358	80,158	135,081		135,081	85,972	221,053		21
22	Employee Benefits & Payroll Taxes			250,713	250,713		250,713	38,413	289,126		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,082	1,082		1,082	758	1,840		24
25	Other Admin. Staff Transportation			10,596	10,596		10,596	28,517	39,113		25
26	Insurance-Prop.Liab.Malpractice			100,018	100,018		100,018	1,479	101,497		26
27	Other (specify):*										27
28	TOTAL General Administration	109,232	19,358	659,074	787,664		787,664	32,327	819,991		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,464,880	300,348	1,072,190	2,837,418		2,837,418	75,025	2,912,443		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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			12,286	12,286		12,286	7,656	19,942			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,401	40,401		40,401	13,373	53,774			32
33	Real Estate Taxes			48,000	48,000		48,000	4,176	52,176			33
34	Rent-Facility & Grounds			299,400	299,400		299,400	9,314	308,714			34
35	Rent-Equipment & Vehicles			8,804	8,804		8,804	297	9,101			35
36	Other (specify):*											36
37	TOTAL Ownership			408,891	408,891		408,891	34,816	443,707			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,613	15,578	102,191		102,191		102,191			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		86,613	102,631	189,244		189,244		189,244			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,464,880	386,961	1,583,712	3,435,553		3,435,553	109,841	3,545,394			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:

01/01/09

Ending:

12/31/09

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	(1,361)	11		4
5	Telephone, TV & Radio in Resident Rooms	(9,618)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	846	30		9
10	Interest and Other Investment Income	(2,732)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(34,153)	21		18
19	Entertainment	(4,499)	21		19
20	Contributions	(371)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(160)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,128)	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	(5,706)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,940)		\$	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)	179,781		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 179,781		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 109,841		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: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To offset Dues/Subscriptions reimbursement	\$ (48)	20	1
2	To eliminate gifts and flowers	(3,948)	20	2
3	To eliminate fees associated with collections	(885)	21	3
4	To offset medical records income	(62)	10	4
5	To eliminate PAC Dues	(763)	20	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
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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	(5,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy# 0046672

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(58)	0	0	0	0	0	0	0	0	0	0	(58)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	16,320	0	0	0	0	0	0	0	0	0	16,320	4
5	Heat and Other Utilities	(9,618)	17,418	107	0	0	0	0	0	0	0	0	7,907	5
6	Maintenance	0	(433)	0	0	0	0	0	0	0	0	0	(433)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,676)	33,305	107	0	23,736	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	(62)	0	20,385	0	0	0	0	0	0	0	0	20,323	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,361)	0	0	0	0	0	0	0	0	0	0	(1,361)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,423)	0	20,385	0	18,962	16							
	C. General Administration													
17	Administrative	0	0	(112,988)	0	0	0	0	0	0	0	0	(112,988)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(160)	1,121	5,796	0	0	0	0	0	0	0	0	6,757	19
20	Fees, Subscriptions & Promotions	(16,887)	14	292	0	0	0	0	0	0	0	0	(16,581)	20
21	Clerical & General Office Expenses	(39,908)	17,348	108,532	0	0	0	0	0	0	0	0	85,972	21
22	Employee Benefits & Payroll Taxes	0	10,881	27,532	0	0	0	0	0	0	0	0	38,413	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	758	0	0	0	0	0	0	0	0	758	24
25	Other Admin. Staff Transportation	0	15,390	13,127	0	0	0	0	0	0	0	0	28,517	25
26	Insurance-Prop.Liab.Malpractice	0	584	895	0	0	0	0	0	0	0	0	1,479	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(56,955)	45,338	43,944	0	32,327	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(68,054)	78,643	64,436	0	75,025	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy# 0046672

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	846	4,810	2,000	0	0	0	0	0	0	0	0	7,656	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,732)	16,105	0	0	0	0	0	0	0	0	0	13,373	32
33	Real Estate Taxes	0	3,800	376	0	0	0	0	0	0	0	0	4,176	33
34	Rent-Facility & Grounds	0	0	9,314	0	0	0	0	0	0	0	0	9,314	34
35	Rent-Equipment & Vehicles	0	0	297	0	0	0	0	0	0	0	0	297	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,886)	24,715	11,987	0	34,816	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(69,940)	103,358	76,423	0	0	0	0	0	0	0	0	109,841	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.
				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	4 Laundry	\$ 46,609	Helia Healthcare Services	100.00%	\$ 62,929	\$ 16,320	1
2	V	5 Utilities		Helia Healthcare Services	100.00%	17,418	17,418	2
3	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	2,567	(433)	3
4	V	19 Professional Services		Helia Healthcare Services	100.00%	1,121	1,121	4
5	V	20 Dues, Subscriptions, & Fees		Helia Healthcare Services	100.00%	14	14	5
6	V	21 Clerical & Office Supplies		Helia Healthcare Services	100.00%	17,348	17,348	6
7	V	22 Payroll Taxes & Employee Benefits		Helia Healthcare Services	100.00%	10,881	10,881	7
8	V	25 Other Admin Transportation		Helia Healthcare Services	100.00%	15,390	15,390	8
9	V	26 Insurance		Helia Healthcare Services	100.00%	584	584	9
10	V	30 Depreciation		Helia Healthcare Services	100.00%	4,810	4,810	10
11	V	32 Interest		Helia Healthcare Services	100.00%	16,105	16,105	11
12	V	33 Real Estate Taxes		Helia Healthcare Services	100.00%	3,800	3,800	12
13	V							13
14	Total		\$ 49,609			\$ 152,967	\$ * 103,358	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 107	\$	107	15
16	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	20,385		20,385	16
17	V	17 Management Fees	164,177	Bridgemark Healthcare, LLC	100.00%	51,189		(112,988)	17
18	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	5,796		5,796	18
19	V	20 Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	292		292	19
20	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	108,532		108,532	20
21	V	22 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	27,532		27,532	21
22	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	758		758	22
23	V	25 Other Admin Transportation		Bridgemark Healthcare, LLC	100.00%	13,127		13,127	23
24	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	895		895	24
25	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	2,000		2,000	25
26	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	376		376	26
27	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	9,314		9,314	27
28	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	297		297	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		\$ 164,177			\$ 240,600	\$ *	76,423	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: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	428,811	5	10.66	Distribution	\$ 51,189	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	\$ 51,189		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:

01/01/09

Ending: 12/31/09

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	5	Utilities	Resident Days	272,995	11	\$ 1,007	\$ 29,113	\$ 107	1
2	10	Nursing & Medical Records	Resident Days	272,995	11	191,151	191,151	20,385	2
3	17	Owners Compensation	Resident Days	272,995	11	480,000	29,113	51,189	3
4	19	Professional Fees	Resident Days	272,995	11	54,354	29,113	5,796	4
5	20	Dues, Subscriptions	Resident Days	272,995	11	2,735	29,113	292	5
6	21	Clerical	Resident Days	272,995	11	1,017,715	852,724	108,532	6
7	22	Employee Benefits	Resident Days	272,995	11	258,166	29,113	27,532	7
8	24	Seminars	Resident Days	272,995	11	7,110	29,113	758	8
9	25	Admin Staff Travel	Resident Days	272,995	11	123,093	29,113	13,127	9
10	26	Insurance	Resident Days	272,995	11	8,392	29,113	895	10
11	30	Depreciation	Resident Days	272,995	11	18,757	29,113	2,000	11
12	34	Rent	Resident Days	272,995	11	87,334	29,113	9,314	12
13	35	Equipment Rental	Resident Days	272,995	11	2,787	29,113	297	13
14	33	Real Estate Taxes	Resident Days	272,995	11	3,528	29,113	376	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,256,129	\$ 1,043,875	\$ 240,600	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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.

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	156,666	4	\$ 198,732	\$ 139,247	49,609	\$ 62,929	1
2	5	Utilities	Revenue	156,666	4	55,005		49,609	17,418	2
3	6	Maintenance	Revenue	156,666	4	8,108	1,462	49,609	2,567	3
4	19	Professional Services	Revenue	156,666	4	3,541		49,609	1,121	4
5	20	Dues, Subscriptions, & Fees	Revenue	156,666	4	44		49,609	14	5
6	21	Clerical & Office Supplies	Revenue	156,666	4	54,785	48,744	49,609	17,348	6
7	22	Payroll Taxes & Emp. Benefits	Revenue	156,666	4	34,361		49,609	10,881	7
8	25	Other Admin Transportation	Revenue	156,666	4	48,601		49,609	15,390	8
9	26	Insurance	Revenue	156,666	4	1,844		49,609	584	9
10	30	Depreciation	Revenue	156,666	4	15,191		49,609	4,810	10
11	32	Interest	Revenue	156,666	4	50,861		49,609	16,105	11
12	33	Real Estate Taxes	Revenue	156,666	4	12,000		49,609	3,800	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					\$ 483,073	\$ 189,453		\$ 152,967	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Related Party Allocation - Helia Healthcare</u>			\$ <u>6,192</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 6,192	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Related Party Allocation - Helia Healthcare	2006		\$ 50,951	\$	25	\$ 1,980	\$ 1,980	\$ 4,828	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	"C" Wing Signs		2004	1,752	175	5	175		1,752	9
10	Handrail Molding		2004	1,000	100	5	100		1,000	10
11	Wallpaper		2004	1,740	232	5	232		1,740	11
12	Wallpaper		2004	1,062	159	5	159		1,062	12
13	Room Signs		2004	1,357		10	136	136	816	13
14	Paint Border		2004	2,253		10	225	225	1,350	14
15	Door Handles and Knobs		2004	729		10	73	73	438	15
16	Border for B Wing		2004	582		10	58	58	348	16
17	Wallpaper for C Wing		2004	1,107		10	111	111	666	17
18	Handrails, Brackets		2004	1,093		10	109	109	654	18
19	Wire Smoke Detectors		2004	572		10	57	57	342	19
20	Door Knobs B & C Wings		2004	766		10	77	77	462	20
21	2 Wall A/C Units		2005	1,035	207	5	207		673	21
22	Roof		2006	13,757	1,376	10	1,376		4,586	22
23	Wall A/C		2006	1,143	229	5	229		896	23
24	Smoke Detectors		2006	749	150	5	150		587	24
25	2 A/C Units		2006	1,055	211	5	211		756	25
26	Fence		2006	573	115	5	115		402	26
27	2 Wall A/C Units		2006	1,044	209	5	209		731	27
28	Glass Door and Install		2007	1,210	121	10	121		363	28
29	Roof		2007	17,623	1,762	10	1,762		4,993	29
30	80 Gallon Water Heater		2007	2,829	283	10	283		613	30
31	Trailor for Resident Smokers		2008	1,295	129	10	129		249	31
32	Doors		2008	1,716	114	15	114		209	32
33	Doors		2008	6,837	456	15	456		722	33
34	Wall Air Conditioner		2008	3,040	608	5	608		1,115	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building 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	3 Wall A/C Units	2009	\$ 3,686	\$ 371	5	\$ 371	\$	\$ 371	37
38	New doors, flooring, walcovering for enterence & wing	2009	56,401	1,100	15	1,100		1,100	38
39	Roof Repair	2009	2,000		10				39
40	Call Cords	2009	1,255	63	10	63		63	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49	Related Party Allocation - Helia Healthcare								49
50	Water & Sewer Pipe Installation	2006	603		20	31	31	103	50
51	Plumbing & Heating Installation	2006	720		20	36	36	123	51
52	A/C Unit - 4 Ton	2007	1,735		10	174	174	463	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)		\$ 185,270	\$ 8,170		\$ 11,237	\$ 3,067	\$ 34,576	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:

01/01/09

Ending:

12/31/09

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	\$ 40,103	\$ 3,998	\$ 7,781	\$ 3,783	3-5	\$ 25,151	71
72	Current Year Purchases	4,783	118	274	156	3-5	274	72
73	Fully Depreciated Assets	8,851					8,851	73
74								74
75	TOTALS	\$ 53,737	\$ 4,116	\$ 8,055	\$ 3,939		\$ 34,276	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	\$ 3,063	\$	\$ 399	\$ 399	5	\$ 1,177	76
77	Helia Healthcare Allocation		2006	700		251	251	5	537	77
78										78
79										79
80	TOTALS			\$ 3,763	\$	\$ 650	\$ 650		\$ 1,714	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)	\$ 248,962	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,286	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,942	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,656	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 70,566	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>299,400</u>			3
4	Additions						4
5	<u>Related Party Allocation - Bridgemark</u>			<u>9,314</u>			5
6							6
7	TOTAL			\$ <u>308,714</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 9,101 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

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>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* 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	\$		\$ 85,145	\$		\$ 85,145	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			19,748			19,748	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			82,153			82,153	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				68,367		68,367	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					18,246		18,246	12
13	Other (specify): <u>Lab, X-Ray, Other</u>	39-03				15,578			15,578	13
14	TOTAL			\$		\$ 202,624	\$ 86,613		\$ 289,237	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**# **0046672**Report Period Beginning: **01/01/09**Ending: **12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>54,683</u>)	762,679		3
4	Supply Inventory (priced at <u>Cost</u>)	1,815		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	181		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 765,175	\$	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	108,609		15
16	Equipment, at Historical Cost	46,462		16
17	Accumulated Depreciation (book methods)	(48,245)		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)	\$ 106,826	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 872,001	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,878	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,092		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Rent Payable</u>	24,950		36
37	<u>Due to Bridgemark Healthcare</u>	594,292		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 959,212	\$	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>	180,106		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 180,106	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,139,318	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (267,317)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 872,001	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (74,587)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (74,587)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(192,730)	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)	\$ (192,730)	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)	\$ (267,317)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy# 0046672Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 3,206,457	1
2	Discounts and Allowances for all Levels	(44,884)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,161,573	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	77,047	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 77,047	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,361	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,361	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,732	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,732	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Medical Records Copies</u>	62	28
28a	<u>Dues Reimbursement</u>	48	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 110	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,242,823	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	657,788	31
32	Health Care	1,391,966	32
33	General Administration	787,664	33
B. Capital Expense			
34	Ownership	408,891	34
C. Ancillary Expense			
35	Special Cost Centers	102,191	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)*	\$ 3,435,553	40
41	Income before Income Taxes (line 30 minus line 40)**	(192,730)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (192,730)	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:

01/01/09

Ending:

12/31/09

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	2,064	2,080	\$ 54,199	\$ 26.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,354	5,647	135,878	24.06	3
4	Licensed Practical Nurses	14,807	15,657	266,535	17.02	4
5	CNAs & Orderlies	46,621	49,306	469,644	9.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,727	4,911	49,069	9.99	10
11	Social Service Workers	3,253	3,373	47,570	14.10	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,104	30,282	14.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,851	11,388	96,306	8.46	15
16	Dishwashers					16
17	Maintenance Workers	1,921	2,170	29,224	13.47	17
18	Housekeepers	7,394	7,737	72,906	9.42	18
19	Laundry	1,294	1,348	11,209	8.32	19
20	Administrator	2,080	2,080	73,667	35.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,808	1,982	35,565	17.94	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,508	1,627	22,491	13.82	31
32	Other Health C: MDS	4,129	4,249	70,335	16.55	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	109,875	115,659	\$ 1,464,880 *	\$ 12.67	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	173	\$ 7,281	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant	Quarterly	899	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	999	10-03	39
40	Physical Therapy Consultant	Contract	1,329	10-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	83	4,636	11-03	44
45	Social Service Consultant	45	2,520	12-03	45
46	Other(specify)				46
47	Psych Consultant	Monthly	1,357	12-03	47
48					48
49	TOTAL (lines 35 - 48)	301	\$ 28,621		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: **01/01/09**

Ending: **12/31/09**

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	0.00	\$ 73,667	Workers' Compensation Insurance	\$ 62,133	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	27,714	Advertising: Employee Recruitment	5,887	
				FICA Taxes	111,968	Health Care Worker Background Check		
				Employee Health Insurance	48,237	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	1,632	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	10,762	
				401(k) Match	661	Licenses & Fees	399	
						Late Fees	315	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 73,667	Related Party Allocation - Bridgemark	27,532	Related Party Allocation - Bridgemark	292	
(List each licensed administrator separately.)				Related Party Allocation - Helia Healthcare	10,881	Related Party Allocation - Helia Health	14	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Bridgemark Healthcare LLC - Management Fees			\$ 164,177			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 164,177	TOTAL (agree to Schedule V, line 22, col.8)	\$ 289,126	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,296	
(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
C.J. Schlosser & Co	Accounting Services		\$ 4,270	Section N/A			Out-of-State Travel	\$
Kramer & Frank	Collection Fees		160					
Craig & Craig	Legal Fees		3,453					
Poisinelli, Shalton, Falnigan	Legal Fees		570				In-State Travel	92
Reed Smith	Legal Fees		154					
Donovan Rose Nester	Legal Fees		207					
Miscellaneous Credit	Legal Fees		(22)					
Ceredian	Payroll Processing		6,661				Seminar Expense	990
							Related Party Allocation - Bridgemark	758
TOTAL (agree to Schedule V, line 19, column 3)			\$ 15,453	TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,840

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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

0046672

Report Period Beginning:

01/01/09

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$8,777
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-5 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,084 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Energy
Attachment to Schedule VII A
Related Nursing Homes
12/31/2009

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 Heathcare
Helia Healthcare of Zion
Hillside Rehab & Care Center

Helia Healthcare of Energy
Attachment to Schedule XII B
Equipment Rentals
12/31/2009

<u>Description</u>			
16A	Dish Machine	\$	902
16B	Copier Rental		3,270
16C	Related Party Allocation - Bridgemark		297
16D	Nursing Rental Equipment		4,632
		<u>\$</u>	<u>9,101</u>