

Facility Name & ID Number Helia Healthcare of Energy

0046672 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	7	Intermediate (ICF)	7	2,555	3
4	48	Intermediate/DD	48	17,520	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	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	12,158	919	9,323	22,400	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	4,506			4,506	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,664	919	9,323	26,906	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.03%

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 84 and days of care provided 8,727

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: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia Healthcare of Energy

0046672

Report Period Beginning:

1/1/13

Ending:

12/31/13

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	144,101	24,166	8,424	176,691		176,691		176,691		1
2	Food Purchase		223,271		223,271		223,271	(36)	223,235		2
3	Housekeeping	156,779	22,960		179,739		179,739		179,739		3
4	Laundry	12,702	17,991	74,116	104,809		104,809		104,809		4
5	Heat and Other Utilities			111,662	111,662		111,662	(11,888)	99,774		5
6	Maintenance	46,657	23,003	58,120	127,780		127,780	18,876	146,656		6
7	Other (specify):*										7
8	TOTAL General Services	360,239	311,391	252,322	923,952		923,952	6,952	930,904		8
	B. Health Care and Programs										
9	Medical Director			10,656	10,656		10,656		10,656		9
10	Nursing and Medical Records	1,853,277	88,119	22,315	1,963,711		1,963,711	6,286	1,969,997		10
10a	Therapy		746		746		746		746		10a
11	Activities	34,902	10,000	4,582	49,484		49,484	(852)	48,632		11
12	Social Services	61,619	75	2,615	64,309	(9,276)	55,033		55,033		12
13	CNA Training										13
14	Program Transportation			605	605		605		605		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,949,798	98,940	40,773	2,089,511	(9,276)	2,080,235	5,434	2,085,669		16
	C. General Administration										
17	Administrative	51,127		306,400	357,527	9,276	366,803	(275,262)	91,541		17
18	Directors Fees										18
19	Professional Services			32,959	32,959		32,959	16,243	49,202		19
20	Dues, Fees, Subscriptions & Promotions			84,495	84,495		84,495	(63,230)	21,265		20
21	Clerical & General Office Expenses	62,089	26,452	100,693	189,234		189,234	189,356	378,590		21
22	Employee Benefits & Payroll Taxes			449,726	449,726		449,726	34,123	483,849		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,285	6,285		6,285	5,449	11,734		24
25	Other Admin. Staff Transportation			26,924	26,924		26,924	10,826	37,750		25
26	Insurance-Prop.Liab.Malpractice			39,300	39,300		39,300	2,727	42,027		26
27	Other (specify):*										27
28	TOTAL General Administration	113,216	26,452	1,046,782	1,186,450	9,276	1,195,726	(79,768)	1,115,958		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,423,253	436,783	1,339,877	4,199,913		4,199,913	(67,382)	4,132,531		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:

1/1/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			58,788	58,788		58,788	8,587	67,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			121,935	121,935		121,935	(37,491)	84,444			32
33	Real Estate Taxes			47,901	47,901		47,901	3,039	50,940			33
34	Rent-Facility & Grounds			326,869	326,869		326,869	12,925	339,794			34
35	Rent-Equipment & Vehicles			27,161	27,161		27,161	(6,891)	20,270			35
36	Other (specify):*											36
37	TOTAL Ownership			582,654	582,654		582,654	(19,831)	562,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		344,333	773,414	1,117,747		1,117,747		1,117,747			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,296	178,296		178,296		178,296			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		344,333	951,710	1,296,043		1,296,043		1,296,043			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,423,253	781,116	2,874,241	6,078,610		6,078,610	(87,213)	5,991,397			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: 1/1/13

Ending: 12/31/13

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	(852)	11		4
5	Telephone, TV & Radio in Resident Rooms	(13,056)	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	844	30		9
10	Interest and Other Investment Income	(37,491)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	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	(957)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,979)	21		19
20	Contributions	(203)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(250)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(57,087)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,476)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,543)		\$	30

BHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	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)	32,330	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,330		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (87,213)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Healthcare of Energy

ID# 0046672

Report Period Beginning: 1/1/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts & Flowers	\$ (5,893)	20	1
2	Offset Medical Records Income	(221)	10	2
3	Eliminate Out of State Travel	(362)	24	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		(6,476)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy# 0046672

Report Period Beginning:

1/1/13

Ending:

12/31/13

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	(36)	0	0	0	0	0	0	0	0	0	0	(36)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(13,056)	946	222	0	0	0	0	0	0	0	0	(11,888)	5
6	Maintenance	0	18,876	0	0	0	0	0	0	0	0	0	18,876	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,092)	19,822	222	0	6,952	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	(221)	0	6,507	0	0	0	0	0	0	0	0	6,286	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(852)	0	0	0	0	0	0	0	0	0	0	(852)	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	(1,073)	0	6,507	0	5,434	16							
	C. General Administration													
17	Administrative	0	0	(275,262)	0	0	0	0	0	0	0	0	(275,262)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(250)	1,071	15,422	0	0	0	0	0	0	0	0	16,243	19
20	Fees, Subscriptions & Promotions	(63,937)	0	707	0	0	0	0	0	0	0	0	(63,230)	20
21	Clerical & General Office Expenses	(4,182)	1,314	192,224	0	0	0	0	0	0	0	0	189,356	21
22	Employee Benefits & Payroll Taxes	0	8,876	25,247	0	0	0	0	0	0	0	0	34,123	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(362)	0	5,811	0	0	0	0	0	0	0	0	5,449	24
25	Other Admin. Staff Transportation	0	6,474	4,352	0	0	0	0	0	0	0	0	10,826	25
26	Insurance-Prop.Liab.Malpractice	0	238	2,489	0	0	0	0	0	0	0	0	2,727	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(68,731)	17,973	(29,010)	0	(79,768)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,896)	37,795	(22,281)	0	(67,382)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy# 0046672

Report Period Beginning:

1/1/13

Ending:

12/31/13

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	844	884	6,859	0	0	0	0	0	0	0	0	8,587	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37,491)	0	0	0	0	0	0	0	0	0	0	(37,491)	32
33	Real Estate Taxes	0	3,000	39	0	0	0	0	0	0	0	0	3,039	33
34	Rent-Facility & Grounds	0	1,680	11,245	0	0	0	0	0	0	0	0	12,925	34
35	Rent-Equipment & Vehicles	0	0	(6,891)	0	0	0	0	0	0	0	0	(6,891)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(36,647)	5,564	11,252	0	(19,831)	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)	(119,543)	43,359	(11,029)	0	0	0	0	0	0	0	0	(87,213)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Helia Healthcare Services	100.00%	\$ 946	\$ 946	1
2	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	21,876	18,876	2
3	V	19 Professional Services		Helia Healthcare Services	100.00%	1,071	1,071	3
4	V	21 Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,314	1,314	4
5	V	22 Payroll Taxes & Employee Benefits		Helia Healthcare Services	100.00%	8,876	8,876	5
6	V	25 Other Admin Transportation		Helia Healthcare Services	100.00%	6,474	6,474	6
7	V	26 Insurance		Helia Healthcare Services	100.00%	238	238	7
8	V	30 Depreciation		Helia Healthcare Services	100.00%	884	884	8
9	V	33 Real Estate Taxes		Helia Healthcare Services	100.00%	3,000	3,000	9
10	V	34 Rent		Helia Healthcare Services	100.00%	1,680	1,680	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,000			\$ 46,359	\$ * 43,359	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%	\$ 222	\$	222	15
16	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	6,507		6,507	16
17	V	17 Administrative	306,400	Bridgemark Healthcare, LLC	100.00%	31,138		(275,262)	17
18	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	15,422		15,422	18
19	V	20 Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	707		707	19
20	V	21 Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	192,178		192,178	20
21	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	25,247		25,247	21
22	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,811		5,811	22
23	V	25 Other Admin Transportation		Bridgemark Healthcare, LLC	100.00%	4,352		4,352	23
24	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	2,489		2,489	24
25	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	5,062		5,062	25
26	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	39		39	26
27	V	34 Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	10,754		10,754	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21 Clerical & General Office Expenses		Bridgemark Medical Supply	100.00%	46		46	32
33	V	30 Depreciation		Bridgemark Medical Supply	100.00%	1,797		1,797	33
34	V	34 Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	491		491	34
35	V	35 Equipment Rental	6,891	Bridgemark Medical Supply	100.00%			(6,891)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 313,291			\$ 302,262	\$ *	(11,029)	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:

1/1/13

Ending:

12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	270,451	5.16	10.32	Distribution	\$ 31,138	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	\$ 31,138		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:

1/1/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	5	Utilities	Resident Days	260,600	10	\$ 2,150	\$ 26,906	\$ 222	1
2	10	Nursing & Medical Records	Resident Days	260,600	10	63,025	26,906	6,507	2
3	17	Owners Compensation	Resident Days	260,600	10	301,589	26,906	31,138	3
4	19	Professional Fees	Resident Days	260,600	10	149,373	26,906	15,422	4
5	20	Dues, Subscriptions	Resident Days	260,600	10	6,850	26,906	707	5
6	21	Salaries - Other	Resident Days	260,600	10	1,295,190	1,295,190	133,724	6
7	21	Clerical & Office Supplies	Resident Days	260,600	10	566,161	26,906	58,454	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	260,600	10	244,527	26,906	25,247	8
9	24	Seminars	Resident Days	260,600	10	56,285	26,906	5,811	9
10	25	Admin Staff Travel	Resident Days	260,600	10	42,147	26,906	4,352	10
11	26	Insurance	Resident Days	260,600	10	24,107	26,906	2,489	11
12	30	Depreciation	Resident Days	260,600	10	49,028	26,906	5,062	12
13	33	Real Estate Taxes	Resident Days	260,600	10	374	26,906	39	13
14	34	Building Rent	Resident Days	260,600	10	95,749	26,906	9,886	14
15	34	Rental - Storage Unit	Resident Days	260,600	10	8,407	26,906	868	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,904,962	\$ 1,358,215	\$ 299,928	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

1/1/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Revenue	12,000	4	\$ 3,782	\$ 3,000	\$ 946	1
2	6	Maintenance	Revenue	12,000	4	87,502	87,502	21,876	2
3	19	Professional Services	Revenue	12,000	4	4,285	3,000	1,071	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	5,255	3,000	1,314	4
5	22	Payroll Taxes & Emp. Ben.	Revenue	12,000	4	35,504	3,000	8,876	5
6	25	Other Admin Transportation	Revenue	12,000	4	25,895	3,000	6,474	6
7	26	Insurance	Revenue	12,000	4	950	3,000	238	7
8	30	Depreciation	Revenue	12,000	4	3,535	3,000	884	8
9	33	Real Estate Taxes	Revenue	12,000	4	12,000	3,000	3,000	9
10	34	Rent	Revenue	12,000	4	6,720	3,000	1,680	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 185,428	\$ 87,502	\$ 46,359	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672 Report Period Beginning: 1/1/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Bridgemark Medical Supply
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & Office Supplies	Revenue	98,304	7	\$ 651	\$ 6,891	\$ 46	1
2	30	Depreciation	Revenue	98,304	7	25,634	6,891	1,797	2
3	34	Rent	Revenue	98,304	7	7,010	6,891	491	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	TOTALS					\$ 33,295	\$	\$ 2,334	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Helia Healthcare of Energy

0046672

Report Period Beginning:

1/1/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
A. Directly Facility Related																
Long-Term																
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	MidCap Funding I, LLC		X		10/22/2009					Variable	121,935	6				
7												7				
8												8				
9	TOTAL Facility Related					\$40,108.00	\$	\$			\$ 121,935	9				
B. Non-Facility Related*																
10	Interest Income		X								(37,491)	10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (37,491)	14				
15	TOTALS (line 9+line14)						\$	\$			\$ 84,444	15				

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2012 report.		\$			1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	47,901		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	47,901		3														
4. Real Estate Tax accrual used for 2013 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.		\$	47,901		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	37,033	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	38,257	9																
	2010	31,655	10																
	2011	33,426	11																
	2012	33,547	12																
47,901 Line 7, Real Estate Tax portion of Lease Payment																			
3,000 Helia Healthcare Allocation																			
39 Bridgemark Healthcare Allocation																			
50,940 Total Schedule V, Line 33																			

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

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

1/1/13 Ending:

12/31/13

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).
Home 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>1,250</u>	1
2					2
3	TOTALS			\$ <u>1,250</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		Related Party Allocation-Helia Healthcare	2006		\$ 7,451	\$	25	\$ 372	\$ 372	\$ 2,918	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		"C" Wing Signs		2004	1,752		5				9
10		Handrail Molding		2004	1,000		5				10
11		Wallpaper		2004	1,740		5				11
12		Wallpaper		2004	1,062		5				12
13		Room Signs		2004	1,357		10	135	135		13
14		Paint Border		2004	2,253		10	225	225		14
15		Door Handles and Knobs		2004	729		10	73	73		15
16		Border for B Wing		2004	582		10	59	59		16
17		Wallpaper for C Wing		2004	1,107		10	110	110		17
18		Handrails, Brackets		2004	1,093		10	109	109		18
19		Wire Smoke Detectors		2004	572		10	58	58		19
20		Door Knobs B & C Wings		2004	766		10	75	75		20
21		2 Wall A/C Units		2005	1,035		5				21
22		Roof		2006	13,757	1,376	10	1,376			22
23		5 Wall A/C		2006	3,242		5				23
24		Smoke Detectors		2006	749		5				24
25		Fence		2006	573		5				25
26		Glass Door and Install		2007	1,210	121	10	121			26
27		Roof		2007	17,623	1,762	10	1,762			27
28		80 Gallon Water Heater		2007	2,829	283	10	283			28
29		Trailer for Resident Smokers		2008	1,295	129	10	129			29
30		Doors		2008	8,553	570	15	570			30
31		Wall Air Conditioner		2008	3,040	101	5	101			31
32		3 Wall A/C Units		2009	3,686	737	5	737			32
33		New Doors, Flooring, wallcovering for entrance & Wing		2009	56,401	3,760	15	3,760			33
34		Roof Repair		2009	2,000	200	10	200			34
35		Call Cords		2009	1,255	125	10	125			35
36		Exterior Brickwork Improvements		2010	7,712	308	25	308			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:

1/1/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	New Asphalt Parking Lot	2010	\$ 22,840	\$ 2,855	8	\$ 2,855	\$	\$	37
38	Heat/Water Pump System	2010	9,800	980	10	980			38
39	A/C Compressor Replacement	2010	1,999	133	15	133			39
40	Fire Protection System: Arch Wing	2010	7,971	319	25	319			40
41	15 Heat/Cool Wall Units	2010	7,753	1,551	5	1,551			41
42	10 Heat/Cool Wall Units	2010	5,530	1,106	5	1,106			42
43	Phone System	2010	17,144	1,714	10	1,714			43
44	S Hall (22 rms) - New doors, windows, bathrooms, paint, drywall, f	2011	56,140	3,743	15	3,743			44
45	W Hall (6 Rms) - New doors, windows, bathrooms, drywall, paint,	2011	22,456	1,497	15	1,497			45
46	Nurse's Station Improvements - New cabinets, counter, wiring, floo	2011	22,456	1,497	15	1,497			46
47	Dining Room - Flooring, drywall, lighting fixtures, paint	2011	33,684	2,246	15	2,246			47
48	Resident Lounge Area - Electrical, lighting fixtures, drywall, paint,	2011	22,456	1,497	15	1,497			48
49	Resident Kitchen Area - New sinks, flooring, wiring, drywall, paint	2011	11,228	749	15	749			49
50	Therapy Room - Flooring, drywall, paint, lighting, windows, labor	2011	22,456	1,497	15	1,497			50
51	2 Shower Rooms - Tile, shower heads, fixtures, paint, new plumbin	2011	33,684	2,246	15	2,246			51
52	Arch (Rehab) Unit - Labor, doors, windows, drywall, paint, floorin	2011	70,667	4,778	15	4,778			52
53	Arch unit continued - fire alarms, plumbing, architect fees								53
54	Exterior Brickwork Improvements	2011	3,600	240	15	240			54
55	21 Wall A/C Units	2011	8,691	1,738	5	1,738			55
56	New Central Air Unit on A Wing	2012	2,700	270	10	270			56
57	Flooring	2012	1,780	356	5	356			57
58	Door Monitors & Keypads	2012	1,707	171	10	171			58
59	Heat/Cool Wall Units	2012	4,580	916	5	916			59
60	Bed Addition in ARCH Unit	2013	34,951	583	25	583			60
61	Heating/Cool Units	2013	3,919	457	5	457			61
62	Related Party Allocation - Helia Healthcare								62
63	Water & Sewer Pipe Installation	2006	476		20	25	25	176	63
64	Plumbing & Heating Installation	2006	569		20	29	29	211	64
65	A/C Unit - 4 Ton	2007	1,370		10	137	137	913	65
66									66
67	Related Party Allocation - Bridgemark Healthcare								67
68	New Office Build-Out	2011	14,023		20	743	743	1,822	68
69	Conference Rm Chair Rail & Paint	2012	159		5	32	32	42	69
70	TOTAL (lines 4 thru 69)		\$ 593,213	\$ 42,611		\$ 44,793	\$ 2,182	\$ 6,082	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 26,215	\$ 14,095	\$ 19,293	\$ 5,198	3-15	\$ 11,770	71
72	Current Year Purchases	7,098		784	784	3-15	784	72
73	Fully Depreciated Assets	12,689					12,689	73
74								74
75	TOTALS	\$ 46,002	\$ 14,095	\$ 20,077	\$ 5,982		\$ 25,243	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	2010	\$ 2,032	\$ 508	\$ 508		4		76
77	Facility	Van	2010	6,294	1,574	1,574		4		77
78	Related Party Allocation - Bridgemark			1,372		143	143	5	1,372	78
79	Related Party Allocation - Helia			1,678		280	280	5	1,655	79
80	TOTALS			\$ 11,376	\$ 2,082	\$ 2,505	\$ 423		\$ 3,027	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)	\$ 651,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,788	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,375	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,587	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 34,352	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:		139		\$ 325,356			3
4	Additions							4
5	Related Party Allocations				12,925			5
6	Storage Rental				1,513			6
7	TOTAL		139		\$ 339,794			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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 N/A.

N/A

N/A

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: \$ 20,270

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	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 1/1/13 Ending: 12/31/13
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	10a,2	hrs	\$		\$	45		\$	45	1	
2	Licensed Speech and Language Development Therapist		hrs								2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10a,2	hrs				701			701	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39,2	# of prescrpts				306,775			306,775	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): <u>Wound, Oxy</u>	39,2					37,558			37,558	12	
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3					773,414			773,414	13	
14	TOTAL			\$		\$	773,414	\$	345,079	\$	1,118,493	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: 1/1/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	\$ 2,571	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,200</u>)	1,205,663		3
4	Supply Inventory (priced at)			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>	89,250		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,297,484	\$	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	33,857		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 33,857	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,331,341	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,195,684	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,388		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,864		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,857		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Provider Assessments</u>	27,298		36
37	<u>Due to Related Parties</u>	788,088		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,163,179	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	180,106		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 180,106	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,343,285	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,011,944)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,331,341	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,145,409)	1
2	Restatements (describe):		2
3	Prior Year Adjustments made after cost report finalized:		3
4	Accounts Receivable Adjustments	45,667	4
5	W/C and Unemployment Adjustment	3,801	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,095,941)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	83,997	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)	\$ 83,997	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,011,944)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 6,096,772	1	
2	Discounts and Allowances for all Levels	8,298	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,105,070	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	21,714	6	
7	Oxygen	1,986	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 23,700	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	43	13	
14	Non-Patient Meals	852	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)	\$ 895	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	37,491	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,491	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)	(9,270)	27	
28	Medical Record Copies	221	28	
28a	Miscellaneous	4,500	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,549)	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,162,607	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	923,952	31	
32	Health Care	2,089,511	32	
33	General Administration	1,186,450	33	
B. Capital Expense				
34	Ownership	582,654	34	
C. Ancillary Expense				
35	Special Cost Centers	1,117,747	35	
36	Provider Participation Fee	178,296	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,078,610	40	
41	Income before Income Taxes (line 30 minus line 40)**	83,997	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 83,997	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,734,829	44
45	Private Pay - Net Inpatient Revenue	124,625	45
46	Medicare - Net Inpatient Revenue	4,011,344	46
47	Other-(specify) <u>Insurance</u>	224,963	47
48	Other-(specify) <u>Hospice</u>	9,309	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,105,070	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,810	2,097	\$ 70,561	\$ 33.65	1
2	Assistant Director of Nursing	2,203	2,444	81,758	33.45	2
3	Registered Nurses	14,140	14,975	393,271	26.26	3
4	Licensed Practical Nurses	25,854	27,493	517,039	18.81	4
5	CNAs & Orderlies	54,444	57,590	638,566	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,449	3,609	34,902	9.67	10
11	Social Service Workers	3,324	3,581	52,343	14.62	11
12	Dietician					12
13	Food Service Supervisor	1,823	1,959	32,690	16.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,211	12,098	111,411	9.21	15
16	Dishwashers					16
17	Maintenance Workers	2,414	2,580	46,657	18.08	17
18	Housekeepers	12,919	14,072	156,779	11.14	18
19	Laundry	1,461	1,460	12,702	8.70	19
20	Administrator	1,451	1,645	51,127	31.08	20
21	Assistant Administrator	462	505	9,276	18.37	21
22	Other Administrative	1,894	2,077	22,664	10.91	22
23	Office Manager	1,875	2,139	39,425	18.43	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)	13,252	14,085	152,082	10.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,986	164,409	\$ 2,423,253 *	\$ 14.74	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	\$ 8,424	1,3	35
36	Medical Director	10,656	9,3	36
37	Medical Records Consultant	1,776	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,412	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	200	10,3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	4,582	11,3	44
45	Social Service Consultant	2,615	12,3	45
46	Other(specify)			46
47	Psych Consultant	8,000	10,3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 38,665		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

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy

0046672

Report Period Beginning: 1/1/13

Ending: 12/31/13

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,495 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. \$ 178,296
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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?
 - 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Helia Healthcare of Energy
Attachment to Schedule XII B
Equipment Rentals
12/31/2013

Description		
16A	Nursing Equipment	\$ 12,585
16B	Dietary Equipment	316
16C	Copier Lease	7,369
		<u>\$ 20,270</u>

