FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0046672

Facility Name: Helia HC of Energy

Address: 210 E College Box 519 (Number) Energy (City) 62933 (Zip Code)

County: Williamson

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618)465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002
(Telephone) (618)465-7717 Fax # (618)465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

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

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	7	Intermediate (ICF)	7	2,562	3
4	48	Intermediate/DD	48	17,568	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,874	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,022	1,514	7,758	25,294	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	4,082			4,082	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,104	1,514	7,758	29,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.74%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 7,372

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	139,121	24,272	9,074	172,467		172,467		172,467			1
2	Food Purchase		197,666		197,666		197,666	(50)	197,616			2
3	Housekeeping	125,699	19,820	296	145,815		145,815		145,815			3
4	Laundry	13,910	17,100	62,788	93,798		93,798		93,798			4
5	Heat and Other Utilities			118,630	118,630		118,630	(11,539)	107,091			5
6	Maintenance	43,996	20,939	47,871	112,806		112,806	16,523	129,329			6
7	Other (specify):*											7
8	**TOTAL General Services**	322,726	279,797	238,659	841,182		841,182	4,934	846,116			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,745,451	75,729	10,631	1,831,811		1,831,811	9,523	1,841,334			10
10a	Therapy		1,828		1,828		1,828		1,828			10a
11	Activities	51,224	32,567	7,342	91,133		91,133	(898)	90,235			11
12	Social Services	65,697	109	3,137	68,943		68,943		68,943			12
13	CNA Training											13
14	Program Transportation			963	963		963		963			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,862,372	110,233	31,673	2,004,278		2,004,278	8,625	2,012,903			16
	C. General Administration											
17	Administrative	68,051		283,400	351,451		351,451	(247,728)	103,723			17
18	Directors Fees											18
19	Professional Services			19,349	19,349		19,349	13,351	32,700			19
20	Dues, Fees, Subscriptions & Promotions			87,077	87,077		87,077	(66,570)	20,507			20
21	Clerical & General Office Expenses	58,394	29,789	49,694	137,877		137,877	183,838	321,715			21
22	Employee Benefits & Payroll Taxes			447,597	447,597		447,597	41,733	489,330			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,635	4,635		4,635	3,699	8,334			24
25	Other Admin. Staff Transportation			23,590	23,590		23,590	11,558	35,148			25
26	Insurance-Prop.Liab.Malpractice			18,635	18,635		18,635	1,685	20,320			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,445	29,789	933,977	1,090,211		1,090,211	(58,434)	1,031,777			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,311,543	419,819	1,204,309	3,935,671		3,935,671	(44,875)	3,890,796			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 HC of Energy #0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,278	55,278		55,278	13,747	69,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,237	131,237		131,237	12,741	143,978			32
33	Real Estate Taxes			48,000	48,000		48,000	3,120	51,120			33
34	Rent-Facility & Grounds			323,660	323,660		323,660	15,565	339,225			34
35	Rent-Equipment & Vehicles			127,948	127,948		127,948	(118,814)	9,134			35
36	Other (specify):*											36
37	**TOTAL Ownership**			686,123	686,123		686,123	(73,641)	612,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		296,966	764,178	1,061,144		1,061,144		1,061,144			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			300,522	300,522		300,522		300,522			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		296,966	1,064,700	1,361,666		1,361,666		1,361,666			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,311,543	716,785	2,955,132	5,983,460		5,983,460	(118,516)	5,864,944			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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(898)	11		4
5	Telephone, TV & Radio in Resident Rooms	(13,733)	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	1,491	30		9
10	Interest and Other Investment Income	(151)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(50)	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	(935)	20		17
18	Fines and Penalties	(6,338)	21		18
19	Entertainment	(6,049)	21		19
20	Contributions	(445)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(25)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(60,211)	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	(6,034)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,378)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(25,138)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (25,138)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (118,516)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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 HC of Energy

ID# 0046672

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (3,766)	20	1
2	Eliminate Lobbying & PAC Dues	(2,056)	20	2
3	Offset Medical Records Income	(212)	10	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**	(6,034)		49

STATE OF ILLINOIS

Summary A

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

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	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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	(13,733)	1,812	382	0	0	0	0	0	0	0	0	(11,539)	5
6	Maintenance	0	16,523	0	0	0	0	0	0	0	0	0	16,523	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,783)	18,335	382	0	0	0	0	0	0	0	0	4,934	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	(212)	0	9,735	0	0	0	0	0	0	0	0	9,523	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(898)	0	0	0	0	0	0	0	0	0	0	(898)	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**	(1,110)	0	9,735	0	0	0	0	0	0	0	0	8,625	16
	C. General Administration													
17	Administrative	0	0	(247,728)	0	0	0	0	0	0	0	0	(247,728)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25)	784	12,592	0	0	0	0	0	0	0	0	13,351	19
20	Fees, Subscriptions & Promotions	(66,968)	0	398	0	0	0	0	0	0	0	0	(66,570)	20
21	Clerical & General Office Expenses	(12,832)	1,221	195,449	0	0	0	0	0	0	0	0	183,838	21
22	Employee Benefits & Payroll Taxes	0	7,932	33,801	0	0	0	0	0	0	0	0	41,733	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,699	0	0	0	0	0	0	0	0	3,699	24
25	Other Admin. Staff Transportation	0	5,236	6,322	0	0	0	0	0	0	0	0	11,558	25
26	Insurance-Prop.Liab.Malpractice	0	287	1,398	0	0	0	0	0	0	0	0	1,685	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(79,825)	15,460	5,931	0	0	0	0	0	0	0	0	(58,434)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(94,718)	33,795	16,048	0	0	0	0	0	0	0	0	(44,875)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense D. Ownership	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)	
30	Depreciation	1,491	1,733	10,523	0	0	0	0	0	0	0	0	13,747	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(151)	8,792	4,100	0	0	0	0	0	0	0	0	12,741	32
33	Real Estate Taxes	0	3,000	120	0	0	0	0	0	0	0	0	3,120	33
34	Rent-Facility & Grounds	0	1,650	13,915	0	0	0	0	0	0	0	0	15,565	34
35	Rent-Equipment & Vehicles	0	0	(118,814)	0	0	0	0	0	0	0	0	(118,814)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,340	15,175	(90,156)	0	0	0	0	0	0	0	0	(73,641)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,378)	48,970	(74,108)	0	0	0	0	0	0	0	0	(118,516)	45

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

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Helia Healthcare Services	100.00%	$ 1,812	$ 1,812	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	19,523	16,523	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	784	784	3
4	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,221	1,221	4
5	V	22	Payroll Taxes & Employee Benefits		Helia Healthcare Services	100.00%	7,932	7,932	5
6	V	25	Other Admin Transportation		Helia Healthcare Services	100.00%	5,236	5,236	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	287	287	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	1,733	1,733	8
9	V	32	Interest		Helia Healthcare Services	100.00%	8,792	8,792	9
10	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,000	3,000	10
11	V	34	Rent		Helia Healthcare Services	100.00%	1,650	1,650	11
12	V								12
13	V								13
14	Total			$ 3,000			$ 51,970	$ * 48,970	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 382	$ 382	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	9,735	9,735	16
17	V	17	Administrative	283,400	Bridgemark Healthcare, LLC	100.00%	35,672	(247,728)	17
18	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	12,592	12,592	18
19	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	398	398	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	195,143	195,143	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	33,801	33,801	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,699	3,699	22
23	V	25	Other Admin Transportation		Bridgemark Healthcare, LLC	100.00%	6,322	6,322	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,398	1,398	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,984	4,984	25
26	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	3,463	3,463	26
27	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	120	120	27
28	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	11,409	11,409	28
29	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	319	319	29
30	V								30
31	V								31
32	V	21	Clerical & General Office Expenses		Bridgemark Medical Supply	100.00%	306	306	32
33	V	30	Depreciation		Bridgemark Medical Supply	100.00%	5,539	5,539	33
34	V	32	Interest		Bridgemark Medical Supply	100.00%	637	637	34
35	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	2,506	2,506	35
36	V	35	Equipment Rental	119,133	Bridgemark Medical Supply	100.00%		(119,133)	36
37	V								37
38	V								38
39	Total			$ 402,533			$ 328,425	$ * (74,108)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			Helia Healthcare of Rolla	Rolla, MO				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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	300,953	5.3	10.60	Distribution	$ 35,672	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	$ 35,672		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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Bridgemark Healthcare, LLC
Street Address: 11970 Borman Drive, Suite 100
City / State / Zip Code: St. Louis, MO 63146
Phone Number: ((314)431-0511
Fax Number: ((314)754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	277,215	11	$ 3,605	$	29,376	$ 382	1
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	29,376	9,735	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625		29,376	35,672	3
4	19	Professional Fees	Resident Days	277,215	11	118,827		29,376	12,592	4
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754		29,376	398	5
6	21	Salaries - Other	Resident Days	277,215	11	1,345,667	1,345,667	29,376	142,598	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853		29,376	52,545	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977		29,376	33,801	8
9	24	Seminars	Resident Days	277,215	11	34,902		29,376	3,699	9
10	25	Admin Staff Travel	Resident Days	277,215	11	59,659		29,376	6,322	10
11	26	Insurance	Resident Days	277,215	11	13,196		29,376	1,398	11
12	30	Depreciation	Resident Days	277,215	11	47,029		29,376	4,984	12
13	32	Interest	Resident Days	277,215	11	32,681		29,376	3,463	13
14	33	Real Estate Taxes	Resident Days	277,215	11	1,133		29,376	120	14
15	34	Building Rent	Resident Days	277,215	11	103,521		29,376	10,970	15
16	34	Rental - Storage Unit	Resident Days	277,215	11	4,139		29,376	439	16
17	35	Equipment Rental	Resident Days	277,215	11	3,007		29,376	319	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,014,442	$ 1,437,534		$ 319,437	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Revenue	12,000	4	$ 7,249	$	3,000	$ 1,812	1
2	6	Maintenance	Revenue	12,000	4	78,091	75,311	3,000	19,523	2
3	19	Professional Services	Revenue	12,000	4	3,135		3,000	784	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	4,882		3,000	1,221	4
5	22	Payroll Taxes & Emp. Ben.	Revenue	12,000	4	31,729		3,000	7,932	5
6	25	Other Admin Transportation	Revenue	12,000	4	20,942		3,000	5,236	6
7	26	Insurance	Revenue	12,000	4	1,148		3,000	287	7
8	30	Depreciation	Revenue	12,000	4	6,932		3,000	1,733	8
9	32	Interest	Revenue	12,000	4	35,169		3,000	8,792	9
10	33	Real Estate Taxes	Revenue	12,000	4	12,000		3,000	3,000	10
11	34	Rent	Revenue	12,000	4	6,600		3,000	1,650	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					$ 207,877	$ 75,311		$ 51,970	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & Office Supplies	Revenue	336,537	5	$ 865	$	119,133	$ 306	1
2	30	Depreciation	Revenue	336,537	5	15,646		119,133	5,539	2
3	32	Interest	Revenue	336,537	5	1,800		119,133	637	3
4	34	Rent	Revenue	336,537	5	7,080		119,133	2,506	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					$ 25,391	$		$ 8,988	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	131,237	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 131,237	9
	B. Non-Facility Related*											
10	Interest Income		X								(151)	10
11	Related Party Allocation - Bridgemark Healthcare										3,463	11
12	Related Party Allocation - Helia Healthcare										8,792	12
13	Related Party Allocation - Bridgemark Medical Supply										637	13
14	TOTAL Non-Facility Related						$	$			$ 12,741	14
15	TOTALS (line 9+line14)						$	$			$ 143,978	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$ 48,000	2
3. Under or (over) accrual (line 2 minus line 1).		$ 48,000	3
4. Real Estate Tax accrual used for 2012 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.		$ 48,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	35,617	8
	2008	37,033	9
	2009	38,257	10
	2010	31,655	11
	2011	33,426	12

48,000 Line 7, Real Estate tax portion of Lease Payment
3,000 Helia Healthcare Allocation
120 Bridgemark Healthcare Allocation
51,120 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia HC of Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

TELEPHONE (314)431-0511 FAX #: (314)754-9176

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-227-019	Long Term Care	$ 33,426.26	$ 33,426.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,426.26	$ 33,426.26

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation-Helia Healthcare			$ 1,250	1
2					2
3	TOTALS			$ 1,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related Party Allocation-Helia Healthcare		2006		$ 7,451	$	25	$ 372	$ 372	$ 2,546	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	"C" Wing Signs			2004	1,752		5			1,752	9
10	Handrail Molding			2004	1,000		5			1,000	10
11	Wallpaper			2004	1,740		5			1,740	11
12	Wallpaper			2004	1,062		5			1,062	12
13	Room Signs			2004	1,357	136	10	136		1,223	13
14	Paint Border			2004	2,253	225	10	225		2,027	14
15	Door Handles and Knobs			2004	729	73	10	73		687	15
16	Border for B Wing			2004	582	58	10	58		523	16
17	Wallpaper for C Wing			2004	1,107	111	10	111		998	17
18	Handrails, Brackets			2004	1,093	109	10	109		983	18
19	Wire Smoke Detectors			2004	572	57	10	57		514	19
20	Door Knobs B & C Wings			2004	766	77	10	77		691	20
21	2 Wall A/C Units			2005	1,035		5			1,035	21
22	Roof			2006	13,757	1,376	10	1,376		8,713	22
23	5 Wall A/C			2006	3,242		5			3,242	23
24	Smoke Detectors			2006	749		5			749	24
25	Fence			2006	573		5			573	25
26	Glass Door and Install			2007	1,210	121	10	121		726	26
27	Roof			2007	17,623	1,762	10	1,762		10,280	27
28	80 Gallon Water Heater			2007	2,829	283	10	283		1,462	28
29	Trailer for Resident Smokers			2008	1,295	129	10	129		637	29
30	Doors			2008	8,553	570	15	570		2,642	30
31	Wall Air Conditioner			2008	3,040	608	5	608		2,938	31
32	3 Wall A/C Units			2009	3,686	737	5	737		2,582	32
33	New Doors, Flooring, wallcovering for entrance & Wing			2009	56,401	3,760	15	3,760		12,380	33
34	Roof Repair			2009	2,000	200	10	200		600	34
35	Call Cords			2009	1,255	125	10	125		439	35
36	Exterior Brickwork Improvements			2010	7,712	308	25	308		797	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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Asphalt Parking Lot	2010	$ 22,840	$ 2,855	8	$ 2,855	$	$ 5,948	37
38	Heat/Water Pump System	2010	9,800	980	10	980		2,042	38
39	A/C Compressor Replacement	2010	1,999	133	15	133		278	39
40	Fire Protection System: Arch Wing	2010	7,971	319	25	319		664	40
41	15 Heat/Cool Wall Units	2010	7,753	1,551	5	1,551		4,006	41
42	10 Heat/Cool Wall Units	2010	5,530	1,106	5	1,106		2,488	42
43	Phone System	2010	17,144	1,714	10	1,714		3,572	43
44	S Hall (22 rms) - New doors, windows, bathrooms, paint, drywall, f	2011	56,140	3,743	15	3,743		4,990	44
45	W Hall (6 Rms) - New doors, windows, bathrooms, drywall, paint,	2011	22,456	1,497	15	1,497		1,996	45
46	Nurse's Station Improvements - New cabinets, counter, wiring, floo	2011	22,456	1,497	15	1,497		1,996	46
47	Dining Room - Flooring, drywall, lighting fixtures, paint	2011	33,684	2,246	15	2,246		2,994	47
48	Resident Lounge Area - Electrical, lighting fixtures, drywall, paint,	2011	22,456	1,497	15	1,497		1,996	48
49	Resident Kitchen Area - New sinks, flooring, wiring, drywall, paint	2011	11,228	749	15	749		998	49
50	Therapy Room - Flooring, drywall, paint, lighting, windows, labor	2011	22,456	1,497	15	1,497		1,996	50
51	2 Shower Rooms - Tile, shower heads, fixtures, paint, new plumbin	2011	33,684	2,246	15	2,246		2,994	51
52	Arch (Rehab) Unit - Labor, doors, windows, drywall, paint, floorin	2011	70,667	4,857	15	4,778	(79)	6,488	52
53	Arch unit continued - fire alarms, plumbing, architect fees								53
54	Exterior Brickwork Improvements	2011	3,600	240	15	240		320	54
55	21 Wall A/C Units	2011	8,691	1,283	5	1,738	455	3,331	55
56	New Central Air Unit on A Wing	2012	2,700	180	10	180		180	56
57	Flooring	2012	1,780	208	5	208		208	57
58	Door Monitors & Keypads	2012	1,707	71	10	71		71	58
59	Heat/Cool Wall Units	2012	4,580	903	5	903		903	59
60									60
61									61
62	Related Party Allocation - Helia Healthcare								62
63	Water & Sewer Pipe Installation	2006	476		20	23	23	153	63
64	Plumbing & Heating Installation	2006	569		20	29	29	183	64
65	A/C Unit - 4 Ton	2007	1,370		10	137	137	776	65
66									66
67	Related Party Allocation - Bridgemark Healthcare								67
68	New Office Build-Out	2011	14,392		20	762	762	1,108	68
69	Conference Rm Chair Rail & Paint	2012	163		5	11	11	11	69
70	TOTAL (lines 4 thru 69)		$ 554,716	$ 42,197		$ 43,907	$ 1,710	$ 118,231	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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 207,816	$ 9,451	$ 20,504	$ 11,053	3-15	$ 75,762	71
72	Current Year Purchases	17,224	1,548	1,898	350	3-15	1,898	72
73	Fully Depreciated Assets	21,639					21,639	73
74								74
75	TOTALS	$ 246,679	$ 10,999	$ 22,402	$ 11,403		$ 99,299	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	$ 1,270	76
77	Facility	Van	2010	6,294	1,574	1,574		4	4,721	77
78	Related Party Allocation - Bridgemark			1,408		352	352	5	1,261	78
79	Related Party Allocation - Helia			1,678		282	282	5	1,373	79
80	TOTALS			$ 11,412	$ 2,082	$ 2,716	$ 634		$ 8,625	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)	$ 814,057	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,025	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,747	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 226,155	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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: First Healthcare Associates

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		139		$ 323,400			3
4	Additions							4
5	Related Party Allocations				15,565			5
6	Storage Rental				260			6
7	TOTAL		139		$ 339,225 **			7

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,134 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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,2	hrs	$		$	$ 75		$ 75	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				1,753		1,753	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				280,604		280,604	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					16,362		16,362	12
13	Physical, Occupational & Speech Ther Other (specify): X-Ray, Labs	39,3				764,178			764,178	13
14	TOTAL			$		$ 764,178	$ 298,794		$ 1,062,972	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

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 2,513	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 123,238)	1,301,978		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,526		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,307,017	$	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	477,215		15
16	Equipment, at Historical Cost	188,436		16
17	Accumulated Depreciation (book methods)	(157,746)		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): Deposits	49,578		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 557,483	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,864,500	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,168,925	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,634		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,138		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	80,778		36
37	Due To Bridgemark Healthcare	1,460,328		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,829,803	$	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)**	$ 3,009,909	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,145,409)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,864,500	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (904,351)	1
2	Restatements (describe):		2
3	**Prior Year Depreciation adjustment**	(822)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (905,173)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(240,236)	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)**	$ (240,236)	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)**	$ (1,145,409)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,743,185	1
2	Discounts and Allowances for all Levels	(84,600)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,658,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,318	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 83,318	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	898	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)**	$ 898	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 151	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Record Copies	212	28
28a	Miscellaneous	60	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 272	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,743,224	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	841,182	31
32	Health Care	2,004,278	32
33	General Administration	1,090,211	33
	B. Capital Expense		
34	Ownership	686,123	34
	C. Ancillary Expense		
35	Special Cost Centers	1,061,144	35
36	Provider Participation Fee	300,522	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,983,460	40
41	**Income before Income Taxes (line 30 minus line 40)****	(240,236)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (240,236)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,207,237	44
45	Private Pay - Net Inpatient Revenue	86,459	45
46	Medicare - Net Inpatient Revenue	3,238,582	46
47	Other-(specify) Insurance	125,296	47
48	Other-(specify) Hospice	1,011	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,658,585	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,897	2,081	$ 66,965	$ 32.18	1
2	Assistant Director of Nursing	1,867	1,949	56,409	28.94	2
3	Registered Nurses	16,927	17,606	449,166	25.51	3
4	Licensed Practical Nurses	22,937	24,302	440,382	18.12	4
5	CNAs & Orderlies	62,296	64,725	704,214	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,994	2,211	28,315	12.81	8
9	Activity Director					9
10	Activity Assistants	4,218	4,456	51,224	11.50	10
11	Social Service Workers	3,708	4,118	65,697	15.95	11
12	Dietician					12
13	Food Service Supervisor	1,889	2,078	33,425	16.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,150	11,774	105,696	8.98	15
16	Dishwashers					16
17	Maintenance Workers	2,432	2,561	43,996	17.18	17
18	Housekeepers	11,708	12,714	125,699	9.89	18
19	Laundry	1,322	1,540	13,910	9.03	19
20	Administrator	2,004	2,153	68,051	31.61	20
21	Assistant Administrator					21
22	Other Administrative	2,004	2,107	21,050	9.99	22
23	Office Manager	1,934	2,178	37,344	17.15	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,287	158,553	$ 2,311,543 *	$ 14.58	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,074	1,3	35
36	Medical Director		9,600	9,3	36
37	Medical Records Consultant		1,706	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,925	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		7,342	11,3	44
45	Social Service Consultant		3,137	12,3	45
46	Other(specify)				46
47	Psych Consultant		6,000	10,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 39,784		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 HC of Energy # 0046672 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christopher Haake	Administrator	0	$ 9,527
James Burrell	Administrator	0	58,524
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,051

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 283,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 283,400

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,025
Ceridian	Payroll Processing	13,131
Personnel Planners	Unemployment Consultant	2,052
Much Shelist	Legal Fees	116
Kramer & Frank	Collections - Eliminated	25
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 19,349

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,313
Unemployment Compensation Insurance	128,438
FICA Taxes	176,534
Employee Health Insurance	38,165
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,370
Employee Benefits	7,744
Other Employee Insurance	5,033
Related Party Allocation-Bridgemark	33,801
Related Party Allocation-Helia	7,932
TOTAL (agree to Schedule V, line 22, col.8)	$ 489,330

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,766
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	4,423
Dues & Subscriptions	3,571
Late Fees	1,929
Miscellaneous Licenses & Fees	1,430
Related Party Allocation-Bridgemark	398
Advertising	60,211
Less: Public Relations Expense	( )
Non-allowable advertising	(60,211)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,507

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,171
Seminar Expense	2,464
Related Pary Allocation-Bridgemark	3,699
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,334

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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								
					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 HC of Energy **#** 0046672 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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 $2,809**

(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? **3-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,985** 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. $ **300,522**
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? **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.

Helia Healthcare of Carbondale
Attachment to Schedule XII B
Equipment Rentals
12/31/2012

	Description		
16A	Nursing Equipment	$	4,273
16B	Dietary Equipment		948
16C	Copier Lease		3,594
16D	Related Party Allocation - Bridgemark		319
		$	9,134