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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0046672

Facility Name: Helia Healthcare of Energy

Address: 210 E College Bx 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: 02/01/2004

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 01/01/14 to 12/31/14 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 Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	30,660	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,319	1,541	10,449	19,309	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	3,449			3,449	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,768	1,541	10,449	22,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.86%

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 12/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2003 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 7,897

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: 12/31/14 Fiscal Year: 12/31/14

* 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: 01/01/14 Ending: 12/31/14

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	151,403	24,809	7,883	184,095		184,095		184,095			1
2	Food Purchase		228,858		228,858		228,858	(77)	228,781			2
3	Housekeeping	135,555	18,520	798	154,873		154,873		154,873			3
4	Laundry	11,466	13,029	65,081	89,576		89,576		89,576			4
5	Heat and Other Utilities			99,956	99,956		99,956	(9,347)	90,609			5
6	Maintenance	64,259	18,450	54,213	136,922		136,922	15,232	152,154			6
7	Other (specify):*											7
8	**TOTAL General Services**	362,683	303,666	227,931	894,280		894,280	5,808	900,088			8
	B. Health Care and Programs											
9	Medical Director			21,254	21,254		21,254		21,254			9
10	Nursing and Medical Records	1,692,321	91,492	36,307	1,820,120		1,820,120	12,679	1,832,799			10
10a	Therapy		276		276		276		276			10a
11	Activities	26,347	9,326	1,041	36,714		36,714	(576)	36,138			11
12	Social Services	29,363	62	2,688	32,113		32,113		32,113			12
13	CNA Training											13
14	Program Transportation			792	792		792		792			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,748,031	101,156	62,082	1,911,269		1,911,269	12,103	1,923,372			16
	C. General Administration											
17	Administrative	96,776		296,100	392,876		392,876	(241,689)	151,187			17
18	Directors Fees											18
19	Professional Services			27,232	27,232		27,232	5,794	33,026			19
20	Dues, Fees, Subscriptions & Promotions			116,072	116,072		116,072	(80,626)	35,446			20
21	Clerical & General Office Expenses	90,277	31,256	100,199	221,732		221,732	141,291	363,023			21
22	Employee Benefits & Payroll Taxes			424,149	424,149		424,149	30,095	454,244			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,819	4,819		4,819	5,074	9,893			24
25	Other Admin. Staff Transportation			22,623	22,623		22,623	10,921	33,544			25
26	Insurance-Prop.Liab.Malpractice			45,413	45,413		45,413	3,331	48,744			26
27	Other (specify):*											27
28	**TOTAL General Administration**	187,053	31,256	1,036,607	1,254,916		1,254,916	(125,809)	1,129,107			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,297,767	436,078	1,326,620	4,060,465		4,060,465	(107,898)	3,952,567			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Helia Healthcare of Energy #0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			9,313	9,313		9,313	5,986	15,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,553	79,553		79,553	(8,398)	71,155			32
33	Real Estate Taxes			72,710	72,710		72,710	24	72,734			33
34	Rent-Facility & Grounds			358,395	358,395		358,395	11,686	370,081			34
35	Rent-Equipment & Vehicles			58,018	58,018		58,018	(8,969)	49,049			35
36	Other (specify):*											36
37	**TOTAL Ownership**			577,989	577,989		577,989	329	578,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		405,290	877,391	1,282,681		1,282,681		1,282,681			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,073	171,073		171,073		171,073			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		405,290	1,048,464	1,453,754		1,453,754		1,453,754			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,297,767	841,368	2,953,073	6,092,208		6,092,208	(107,569)	5,984,639			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(576)	11		4
5	Telephone, TV & Radio in Resident Rooms	(10,552)	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				9
10	Interest and Other Investment Income	(8,398)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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	(1,195)	20		17
18	Fines and Penalties	(3,460)	21		18
19	Entertainment	(8,407)	21		19
20	Contributions	(1,390)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(169)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(70,352)	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	(9,451)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,027)		$	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)	6,458	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 6,458		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,569)		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 Healthcare of Energy

ID# 0046672

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (8,680)	20	1
2	Eliminate Lobbying & PAC Dues	(1,434)	20	2
3	Record Full Year of IDPH License Fee	663	20	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**	(9,451)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Healthcare of Energy # 0046672 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(77)	0	0	0	0	0	0	0	0	0	0	(77)	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	(10,552)	997	208	0	0	0	0	0	0	0	0	(9,347)	5
6	Maintenance	0	15,232	0	0	0	0	0	0	0	0	0	15,232	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,629)	16,229	208	0	0	0	0	0	0	0	0	5,808	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,679	0	0	0	0	0	0	0	0	12,679	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(576)	0	0	0	0	0	0	0	0	0	0	(576)	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**	(576)	0	12,679	0	0	0	0	0	0	0	0	12,103	16
	C. General Administration													
17	Administrative	0	0	(241,689)	0	0	0	0	0	0	0	0	(241,689)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(169)	1,399	4,564	0	0	0	0	0	0	0	0	5,794	19
20	Fees, Subscriptions & Promotions	(80,998)	0	372	0	0	0	0	0	0	0	0	(80,626)	20
21	Clerical & General Office Expenses	(13,257)	587	153,961	0	0	0	0	0	0	0	0	141,291	21
22	Employee Benefits & Payroll Taxes	0	6,787	23,308	0	0	0	0	0	0	0	0	30,095	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,074	0	0	0	0	0	0	0	0	5,074	24
25	Other Admin. Staff Transportation	0	5,422	5,499	0	0	0	0	0	0	0	0	10,921	25
26	Insurance-Prop.Liab.Malpractice	0	915	2,416	0	0	0	0	0	0	0	0	3,331	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(94,424)	15,110	(46,495)	0	0	0	0	0	0	0	0	(125,809)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(105,629)	31,339	(33,608)	0	0	0	0	0	0	0	0	(107,898)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Healthcare of Energy **#** 0046672 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	0	668	5,318	0	0	0	0	0	0	0	0	5,986	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,398)	0	0	0	0	0	0	0	0	0	0	(8,398)	32
33	Real Estate Taxes	0	0	24	0	0	0	0	0	0	0	0	24	33
34	Rent-Facility & Grounds	0	1,695	9,991	0	0	0	0	0	0	0	0	11,686	34
35	Rent-Equipment & Vehicles	0	0	(8,969)	0	0	0	0	0	0	0	0	(8,969)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,398)	2,363	6,364	0	0	0	0	0	0	0	0	329	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)**	(114,027)	33,702	(27,244)	0	0	0	0	0	0	0	0	(107,569)	45

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical S	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%	$ 997	$ 997	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	18,232	15,232	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	1,399	1,399	3
4	V	21	Clerical & General Office		Helia Healthcare Services	100.00%	587	587	4
5	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	6,787	6,787	5
6	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	5,422	5,422	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	915	915	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	668	668	8
9	V	34	Rent		Helia Healthcare Services	100.00%	1,695	1,695	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,000			$ 36,702	$ * 33,702	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 208	$ 208	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	12,679	12,679	16
17	V	17	Administrative	296,100	Bridgemark Healthcare, LLC	100.00%	54,411	(241,689)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	4,564	4,564	18
19	V	20	Dues, Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	372	372	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	153,949	153,949	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	23,308	23,308	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,074	5,074	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,499	5,499	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,416	2,416	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	3,439	3,439	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	24	24	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	9,549	9,549	27
28	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	203	203	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	21	Clerical & General Office Expenses		Bridgemark Medical Supply	100.00%	12	12	34
35	V	30	Depreciation		Bridgemark Medical Supply	100.00%	1,879	1,879	35
36	V	34	Rent - Facility & Grounds		Bridgemark Medical Supply	100.00%	442	442	36
37	V	35	Equipment Rental	9,172	Bridgemark Medical Supply	100.00%		(9,172)	37
38	V								38
39	Total			$ 305,272			$ 278,028	$ * (27,244)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	539,286	4.58	9.16	Distribution	$ 54,411	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	$ 54,411		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	248,320	10	$ 2,267	$	22,758	$ 208	1
2	10	Nursing & Medical Records	Resident Days	248,320	10	138,347	138,347	22,758	12,679	2
3	17	Owners Compensation	Resident Days	248,320	10	593,697		22,758	54,411	3
4	19	Professional Fees	Resident Days	248,320	10	49,802		22,758	4,564	4
5	20	Dues, Subscriptions	Resident Days	248,320	10	4,062		22,758	372	5
6	21	Salaries - Other	Resident Days	248,320	10	1,347,083	1,347,083	22,758	123,457	6
7	21	Clerical & Office Supplies	Resident Days	248,320	10	332,712		22,758	30,492	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	248,320	10	254,317		22,758	23,308	8
9	24	Seminars	Resident Days	248,320	10	55,362		22,758	5,074	9
10	25	Admin Staff Travel	Resident Days	248,320	10	60,000		22,758	5,499	10
11	26	Insurance	Resident Days	248,320	10	26,357		22,758	2,416	11
12	30	Depreciation	Resident Days	248,320	10	37,526		22,758	3,439	12
13	33	Real Estate Taxes	Resident Days	248,320	10	261		22,758	24	13
14	34	Building Rent	Resident Days	248,320	10	94,122		22,758	8,626	14
15	34	Rental - Storage Unit	Resident Days	248,320	10	10,067		22,758	923	15
16	35	Equipment Rental	Resident Days	248,320	10	2,216		22,758	203	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,008,198	$ 1,485,430		$ 275,695	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 3,989	$	3,000	$ 997	1
2	6	Maintenance	Revenue	12,000	4	72,927	72,927	3,000	18,232	2
3	19	Professional Services	Revenue	12,000	4	5,597		3,000	1,399	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	2,348		3,000	587	4
5	22	Payroll Taxes & Emp. Bene.	Revenue	12,000	4	27,148		3,000	6,787	5
6	25	Other Admin Transportation	Revenue	12,000	4	21,686		3,000	5,422	6
7	26	Insurance	Revenue	12,000	4	3,659		3,000	915	7
8	30	Depreciation	Revenue	12,000	4	2,670		3,000	668	8
9	34	Rent	Revenue	12,000	4	6,780		3,000	1,695	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					$ 146,804	$ 72,927		$ 36,702	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 & General Office	Revenue	129,336	8	$ 168	$	9,172	$ 12	1
2	30	Depreciation	Revenue	129,336	8	26,491		9,172	1,879	2
3	34	Rent	Revenue	129,336	8	6,237		9,172	442	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					$ 32,896	$		$ 2,333	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	79,553	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 79,553	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,398)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,398)	14
15	TOTALS (line 9+line14)						$	$			$ 71,155	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 Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 66,989	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.)		$ 68,822	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,833	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,877	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.		$ 72,710	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	38,257	8
	2010	31,655	9
	2011	33,426	10
	2012	33,547	11
	2013	68,822	12

72,710 Line 7, Real Estate Tax Portion of Lease Payments
24 Bridgemark Healthcare Allocation
72,734 Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Energy COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0046672

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-227-019	Long Term Care	$ 68,822.44	$ 68,822.44
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,822.44	$ 68,822.44

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$ 1,253	1
2					2
3	TOTALS			$ 1,253	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 7,450	$	25	$ 372	$ 372	$ 3,291	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	"C" Wing Sings			2004	1,752						10
11	Handrail Molding			2004	1,000						11
12	Wallpaper			2004	1,740						12
13	Wallpaper			2004	1,062						13
14	Room Signs			2004	1,357						14
15	Paint Border			2004	2,253						15
16	Door Handles and Knobs			2004	729						16
17	Border for B Wing			2004	582						17
18	Wallpaper for C Wing			2004	1,107						18
19	Handrails, Brackets			2004	1,093						19
20	Wire Smoke Detectors			2004	572						20
21	Door Knobs B & C Wing			2004	766						21
22	2 Wall A/C Units			2005	1,035						22
23	Roof			2006	13,757						23
24	5 Wall A/C			2006	3,242						24
25	Smoke Detectors			2006	749						25
26	Fence			2006	573						26
27	Glass Door and Install			2007	1,210						27
28	Roof			2007	17,623						28
29	80 Gallon Water Heater			2007	2,829						29
30	Trailer for Resident Smokers			2008	1,295						30
31	Doors			2008	8,553						31
32	Wall Air Conditioner			2008	3,040						32
33	3 Wall A/C Units			2009	3,686						33
34	New Doors, Flooring, Wallcovering for entrance & Wing			2009	56,401						34
35	Roof Repair			2009	2,000						35
36	Call Cords			2009	1,255						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Exterior Brickwork Improvements	2010	$ 7,712	$		$	$	$	37
38	New Asphalt Parking Lot	2010	22,840						38
39	Heat/Water Pump System	2010	9,800						39
40	A/C Compressor Replacement	2010	1,999						40
41	Fire Protection System: Arch Wing	2010	7,971						41
42	15 Heat/Cool Wall Units	2010	7,753						42
43	10 Heat/Cool Wall Units	2010	5,530						43
44	Phone System	2010	17,144						44
45	S Hall (22rms) - New Doors, Windows, Bathrooms, Paint, Drywall	2011	56,140						45
46	W Hall (6 rms) - New Doors, Windows, Bathrooms, Drywall, Paint	2011	22,456						46
47	Nurse's Station Improvements - New Cabinets, counter, wiring, flo	2011	22,456						47
48	Dining Room - Flooring, drywall lighting fixtures, paint	2011	33,684						48
49	Resident lounge area - electrical, lighting fixtures, drywall, paint	2011	22,456						49
50	Resident Kitchen Area - New sinks, flooring, wiring, drywall, paint	2011	11,228						50
51	Therapy Room - Flooring, drywall, paint, lighting, windows, labor	2011	22,456						51
52	2 Shower Rooms - Tile, Shower heads, fixtures, paint, new plumbin	2011	33,684						52
53	Arch (Rehab) unit - Labor, doors, windows, drywall, paint flooring	2011	70,667						53
54	Arch unit cont. - fire alarms, plumbing, architect fees								54
55	Exterior Brickwork Improvements	2011	3,600						55
56	21 Wall A/C Units	2012	8,691						56
57	New Central Air Unit on A Wing	2012	2,700						57
58	Flooring	2012	1,780						58
59	Door Monitors & Keypads	2012	1,707						59
60	Heat/Cool Wall Units	2012	4,580						60
61	Bed Addition in ARCH unit	2013	34,951						61
62	Heating/Cool Units	2013	3,919						62
63									63
64	4 A/C Units	2014	2,586	43	5	43		43	64
65	Tile, Paint, Vanities, Toilets A-Wing	2014	3,971	364	10	364		364	65
66	Windows, Tile, Doors & Vanities - B-Wing	2014	3,584	239	10	239		239	66
67	A-Wing Nurse's Station	2014	1,450	61	10	61		61	67
68	Windows, Laminate Tops, Paint, Tile - B-Wing	2014	15,282		15				68
69	Kitchen Wiring Install	2014	990	91	10	91		91	69
70	TOTAL (lines 4 thru 69)		$ 604,478	$ 798		$ 1,170	$ 372	$ 4,089	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12A, Carried Forward		$ 604,478	$ 798		$ 1,170	$ 372	$ 4,089	1
2	CTS Tech Phone Line Upgrade/Cabling Install	2014	5,113	446	10	446		446	2
3	Security I - Alarm System Install	2014	1,950	81	10	81		81	3
4	Windows	2014	925	23	10	23		23	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	Related Party Allocation - Helia Healthcare								22
23	Water & Sewer Pipe Installation	2006	475		20	24	24	200	23
24	Pluming & Heating Installation	2006	569		20	29	29	239	24
25	A/C Unit - 4 Ton	2007	1,370		10	137	137	1,050	25
26									26
27	Related Party Allocation - Bridgemark Healthcare								27
28	New Office Build-out	2011	12,447		20	659	659	2,276	28
29	Conference Room Chair Rail & Paint	2012	141		5	28	28	66	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 627,468	$ 1,348		$ 2,597	$ 1,249	$ 8,470	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 29,756	$	$ 4,356	$ 4,356	3-15	$ 14,159	71
72	Current Year Purchases	39,118	6,102	6,459	357	3-15	6,459	72
73	Fully Depreciated Assets	12,523					12,523	73
74								74
75	TOTALS	$ 81,397	$ 6,102	$ 10,815	$ 4,713		$ 33,141	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	2014	$ 9,938	$ 1,863	$ 1,863	$	4	$ 1,863	76
77										77
78	Related Party Allocation - Bridgemark			1,218				5	1,218	78
79	Related Party Allocation - Helia			1,678		24	24	5	1,678	79
80	TOTALS			$ 12,834	$ 1,863	$ 1,887	$ 24		$ 4,759	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)	$ 722,952	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,313	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,299	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,986	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 46,370	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 Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Champaign Williamson Franklin, L.L.C.

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		$ 357,050			3
4	Additions							4
5	Related Party Allocations				11,686			5
6	Storage Rental				1,345			6
7	TOTAL		139		$ 370,081 **			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 12/20/13
Ending 12/19/23

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$ 357,000
13.	/2016	$ 357,000
14.	/2017	$ 357,000

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: $ 49,049 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: 01/01/14 Ending: 12/31/14

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 Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				276		276	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				360,516		360,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					44,774		44,774	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				877,391			877,391	13
14	TOTAL			$		$ 877,391	$ 405,566		$ 1,282,957	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 Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 2,102	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 113,700)	1,076,617		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,653		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	89,250		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,170,622	$	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	32,340		15
16	Equipment, at Historical Cost	62,629		16
17	Accumulated Depreciation (book methods)	(9,313)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	70,877		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	7,009		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 163,542	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,334,164	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,364,857	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,649		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,146		31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,877		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessments	15,114		36
37	Due to Related Parties	811,293		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,385,936	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	180,106		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 180,106	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,566,042	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,231,878)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,334,164	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,011,944)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,011,944)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(219,934)	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)**	$ (219,934)	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)**	$ (1,231,878)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 5,878,878	1
2	Discounts and Allowances for all Levels	(53,856)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,825,022	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,538	6
7	Oxygen	5,793	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 33,331	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	211	13
14	Non-Patient Meals	576	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,024	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	375	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,186	23
	D. Non-Operating Revenue		
24	Contributions	20	24
25	Interest and Other Investment Income***	8,398	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,418	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	1,317	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,317	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,872,274	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	894,280	31
32	Health Care	1,911,269	32
33	General Administration	1,254,916	33
	B. Capital Expense		
34	Ownership	577,989	34
	C. Ancillary Expense		
35	Special Cost Centers	1,282,681	35
36	Provider Participation Fee	171,073	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,092,208	40
41	**Income before Income Taxes (line 30 minus line 40)****	(219,934)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (219,934)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,299,998	44
45	Private Pay - Net Inpatient Revenue	207,138	45
46	Medicare - Net Inpatient Revenue	3,339,949	46
47	Other-(specify) Insurance	927,600	47
48	Other-(specify) Hospice	50,337	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,825,022	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: 01/01/14 Ending: 12/31/14

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	2,011	2,126	$ 77,705	$ 36.55	1
2	Assistant Director of Nursing	1,338	1,598	39,874	24.95	2
3	Registered Nurses	15,787	16,628	430,099	25.87	3
4	Licensed Practical Nurses	21,025	22,959	438,010	19.08	4
5	CNAs & Orderlies	45,204	48,180	555,293	11.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	775	775	11,720	15.12	8
9	Activity Director					9
10	Activity Assistants	2,526	2,802	26,347	9.40	10
11	Social Service Workers	2,339	2,553	29,363	11.50	11
12	Dietician					12
13	Food Service Supervisor	2,073	2,443	33,195	13.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,869	12,768	118,208	9.26	15
16	Dishwashers					16
17	Maintenance Workers	4,034	4,253	64,259	15.11	17
18	Housekeepers	12,592	13,446	135,555	10.08	18
19	Laundry	1,328	1,328	11,466	8.63	19
20	Administrator	1,689	1,749	58,872	33.66	20
21	Assistant Administrator	1,841	2,032	37,904	18.65	21
22	Other Administrative	2,008	2,108	34,157	16.20	22
23	Office Manager	2,084	2,310	34,295	14.85	23
24	Clerical	679	709	21,825	30.78	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)	9,967	11,017	123,048	11.17	30
31	Medical Records	1,146	1,288	16,572	12.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,315	153,072	$ 2,297,767 *	$ 15.01	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		$ 7,883	1,3	35
36	Medical Director		21,254	9,3	36
37	Medical Records Consultant		1,776	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,813	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		1,041	11,3	44
45	Social Service Consultant		2,688	12,3	45
46	Other(specify)				46
47	Psych Consultant		6,250	10,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 43,705		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 Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judy Minor	Asst. Administrator	0	$ 37,904
Loretta Ellis	Administrator	0	58,872
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 96,776

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 296,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 296,100

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 5,407
Ceridian	Payroll Processing	15,197
Personnel Planners, Inc	Unemployment Consultant	2,048
Much Shelist	Legal Fees - State Survey	4,059
Kramer & Frank PC	Collections - Eliminated	169
TransAmerica Retirement Solutions	Retirement Admin Fees	352
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 27,232

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,900
Unemployment Compensation Insurance	101,562
FICA Taxes	176,919
Employee Health Insurance	29,003
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,446
Employee Benefits	5,410
Other Employee Insurance	6,909
Related Party Allocation - Bridgemark	23,308
Related Party Allocation - Helia	6,787
TOTAL (agree to Schedule V, line 22, col.8)	$ 454,244

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	19,882
Health Care Worker Background Check	7,405
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	4,586
Late Fees	885
Miscellaneous Licenses & Fees	326
Related Party Allocation - Bridgemark	372
Advertising	70,362
Less: Public Relations Expense	( )
Non-allowable advertising	(70,362)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,446

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,144
Seminar Expense	2,675
Related Party Allocation - Bridgemark	5,074
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,893

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Healthcare of Energy # 0046672 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 $2,302**

(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. $ **9,865** 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? **Yes**
If YES, give effective date of lease. **12/20/13**

(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. $ **171,073**
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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **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
12/31/2014

	Description	
16A	Nursing Equipment	41,750
16B	Copier Lease	7,047
16C	Dietary Equipment	49
16D	Related Party Allocation - Bridgemark Healthcare	203
		49,049