		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0046268

Facility Name: Frankfort Healthcare & Rehab Center

Address: 2500 East St. Louis Street (Number) West Frankfort (City) 62896 (Zip Code)

County: Franklin

Telephone Number: (618) 932-3236 **Fax #** (618) 937-1171

HFS ID Number:

Date of Initial License for Current Owners: 10/01/03

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 1/01/18 to 12/31/18 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) Jason Mills
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, 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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,315	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	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	11,241	1,563	1,933	14,737	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,241	1,563	1,933	14,737	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.83%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 4/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,366

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	93,475	10,455	4,952	108,882		108,882		108,882			1
2	Food Purchase		89,812		89,812		89,812	(47)	89,765			2
3	Housekeeping	49,126	8,613	14,383	72,122		72,122		72,122			3
4	Laundry	5,338	2,452	72,051	79,841		79,841	(10,181)	69,660			4
5	Heat and Other Utilities			45,459	45,459		45,459	3,497	48,956			5
6	Maintenance	55,467	7,624	22,046	85,137		85,137	39,284	124,421			6
7	Other (specify):*											7
8	**TOTAL General Services**	203,406	118,956	158,891	481,253		481,253	32,553	513,806			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	624,804	53,568	9,049	687,421		687,421	10,389	697,810			10
10a	Therapy		288		288		288	1,596	1,884			10a
11	Activities	32,516	2,608	2,756	37,880		37,880		37,880			11
12	Social Services	39,604		1,703	41,307		41,307		41,307			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	696,924	56,464	19,508	772,896		772,896	11,985	784,881			16
	C. General Administration											
17	Administrative	81,232		94,800	176,032		176,032	(82,876)	93,156			17
18	Directors Fees											18
19	Professional Services			22,094	22,094		22,094	9,447	31,541			19
20	Dues, Fees, Subscriptions & Promotions			40,114	40,114		40,114	(27,599)	12,515			20
21	Clerical & General Office Expenses	24,111	10,097	81,663	115,871		115,871	82,756	198,627			21
22	Employee Benefits & Payroll Taxes			117,009	117,009		117,009	24,774	141,783			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,062	1,062		1,062	2,913	3,975			24
25	Other Admin. Staff Transportation			5,519	5,519		5,519	16,101	21,620			25
26	Insurance-Prop.Liab.Malpractice			71,754	71,754		71,754	894	72,648			26
27	Other (specify):*											27
28	**TOTAL General Administration**	105,343	10,097	434,015	549,455		549,455	26,410	575,865			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,005,673	185,517	612,414	1,803,604		1,803,604	70,948	1,874,552			29

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

SEE ACCOUNTANTS' PREPARATION 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 Frankfort Healthcare & Rehab Center #0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,717	8,717		8,717	4,556	13,273			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,315	40,315		40,315	(4,073)	36,242			32
33	Real Estate Taxes			51,257	51,257		51,257	1,096	52,353			33
34	Rent-Facility & Grounds			244,205	244,205		244,205	6,411	250,616			34
35	Rent-Equipment & Vehicles			15,229	15,229		15,229	472	15,701			35
36	Other (specify):*											36
37	**TOTAL Ownership**			359,723	359,723		359,723	8,462	368,185			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,480	161,787	248,267		248,267	(2,318)	245,949			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			127,437	127,437		127,437		127,437			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		86,480	289,224	375,704		375,704	(2,318)	373,386			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,005,673	271,997	1,261,361	2,539,031		2,539,031	77,092	2,616,123			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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				4
5	Telephone, TV & Radio in Resident Rooms	(4,818)	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	(4,097)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(150)	20		17
18	Fines and Penalties				18
19	Entertainment	(783)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(285)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,597)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,539)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,316)		$	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)	115,408	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 115,408		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 77,092		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' PREPARATION REPORT

Frankfort Healthcare & Rehab Center
ID# 0046268
Report Period Beginning: 1/01/18
Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (2,350)	20	1
2	To Eliminate Lobbying & PAC Dues	(1,199)	20	2
3	To eliminate Unallowed IDPH Fees	(1,990)	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
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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**	(5,539)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	(47)	0	0	0	0	0	0	0	0	0	0	(47)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(10,181)	0	0	0	0	0	0	0	0	(10,181)	4
5	Heat and Other Utilities	(4,818)	306	8,009	0	0	0	0	0	0	0	0	3,497	5
6	Maintenance	0	0	39,284	0	0	0	0	0	0	0	0	39,284	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,865)	306	37,112	0	0	0	0	0	0	0	0	32,553	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	10,388	1	0	0	0	0	0	0	0	0	10,389	10
10a	Therapy	0	0	1,596	0	0	0	0	0	0	0	0	1,596	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	10,388	1,597	0	0	0	0	0	0	0	0	11,985	16
	C. General Administration													
17	Administrative	0	(83,189)	313	0	0	0	0	0	0	0	0	(82,876)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(285)	8,972	760	0	0	0	0	0	0	0	0	9,447	19
20	Fees, Subscriptions & Promotions	(28,286)	687	0	0	0	0	0	0	0	0	0	(27,599)	20
21	Clerical & General Office Expenses	(783)	81,173	2,366	0	0	0	0	0	0	0	0	82,756	21
22	Employee Benefits & Payroll Taxes	0	9,887	14,887	0	0	0	0	0	0	0	0	24,774	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,896	17	0	0	0	0	0	0	0	0	2,913	24
25	Other Admin. Staff Transportation	0	3,355	12,746	0	0	0	0	0	0	0	0	16,101	25
26	Insurance-Prop.Liab.Malpractice	0	593	301	0	0	0	0	0	0	0	0	894	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,354)	24,374	31,390	0	0	0	0	0	0	0	0	26,410	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,219)	35,068	70,099	0	0	0	0	0	0	0	0	70,948	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	831	3,725	0	0	0	0	0	0	0	0	4,556	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,097)	0	24	0	0	0	0	0	0	0	0	(4,073)	32
33	Real Estate Taxes	0	29	1,067	0	0	0	0	0	0	0	0	1,096	33
34	Rent-Facility & Grounds	0	4,264	2,147	0	0	0	0	0	0	0	0	6,411	34
35	Rent-Equipment & Vehicles	0	0	472	0	0	0	0	0	0	0	0	472	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,097)	5,124	7,435	0	0	0	0	0	0	0	0	8,462	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	(2,318)	0	0	0	0	0	0	0	0	(2,318)	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	(2,318)	0	0	0	0	0	0	0	0	(2,318)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(38,316)	40,192	75,216	0	0	0	0	0	0	0	0	77,092	45

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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 Champaign	Champaign, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO			
		Helia Healthcare of Energy	Energy, IL			
		Helia Southbelt Healthcare	Belleville, 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	$	Bridgemark Healthcare, LLC	100.00%	$ 306	$ 306	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	10,388	10,388	2
3	V	17	Management Fees	94,800	Bridgemark Healthcare, LLC	100.00%	11,611	(83,189)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	8,972	8,972	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	687	687	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	81,173	81,173	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	9,887	9,887	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,896	2,896	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,355	3,355	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	593	593	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	831	831	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	29	29	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	4,264	4,264	13
14	Total			$ 94,800			$ 134,992	$ * 40,192	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 390	$ 390	15
16	V								16
17	V	4	Laundry	64,340	Helia Healthcare Services	100.00%	54,159	(10,181)	17
18	V	5	Utilities		Helia Healthcare Services	100.00%	8,009	8,009	18
19	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	42,284	39,284	19
20	V	19	Professional Services		Helia Healthcare Services	100.00%	760	760	20
21	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	2,340	2,340	21
22	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	14,624	14,624	22
23	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	12,714	12,714	23
24	V	26	Insurance		Helia Healthcare Services	100.00%	301	301	24
25	V	30	Depreciation		Helia Healthcare Services	100.00%	3,725	3,725	25
26	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,067	1,067	26
27	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	2,147	2,147	27
28	V	35	Rent - Vehicle		Helia Healthcare Services	100.00%	82	82	28
29	V								29
30	V	10	Nursing & Med		NW Rehab, LLC	100.00%	1	1	30
31	V	10a	Therapy		NW Rehab, LLC	100.00%	1,596	1,596	31
32	V	17	Admin Salaries		NW Rehab, LLC	100.00%	313	313	32
33	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	26	26	33
34	V	22	Employee Benefits & Payroll Taxes		NW Rehab, LLC	100.00%	263	263	34
35	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	17	17	35
36	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	32	32	36
37	V	32	Interest		NW Rehab, LLC	100.00%	24	24	37
38	V	39	Ancillary Service Centers	2,318	NW Rehab, LLC	100.00%		(2,318)	38
39	Total			$ 69,658			$ 144,874	$ * 75,216	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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			Hillside Rehab & Care Center	Yorkville, IL				2
3			Helia Healthcare of Jerseyville	Jerseyville, IL				3
4			Helia Healthcare of Hillsboro	Hillsboro, IL				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6			Helia Healthcare of Florissant	Florissant, MO				6
7			Helia Healthcare of Effingham	Effingham, IL				7
8			Helia Healthcare of Salem	Salem, IL				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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	288,389	1.94	3.87	Distribution	$ 11,611	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	$ 11,611		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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	380,780	15	$ 7,897	$	14,737	$ 306	1
2	10	Nursing & Medical Supplies	Resident Days	380,780	15	268,418	268,418	14,737	10,388	2
3	17	Owner's Compensation	Resident Days	380,780	15	300,000		14,737	11,611	3
4	19	Professional Fees	Resident Days	380,780	15	231,817		14,737	8,972	4
5	20	Dues, Subscriptions	Resident Days	380,780	15	17,755		14,737	687	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	14,737	69,673	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		14,737	11,500	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	380,780	15	255,471		14,737	9,887	8
9	24	Seminars	Resident Days	380,780	15	74,815		14,737	2,896	9
10	25	Admin Staff Travel	Resident Days	380,780	15	86,690		14,737	3,355	10
11	26	Insurance	Resident Days	380,780	15	15,316		14,737	593	11
12	30	Depreciation	Resident Days	380,780	15	21,481		14,737	831	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		14,737	29	13
14	34	Building Rent	Resident Days	380,780	15	102,060		14,737	3,950	14
15	34	Rental - Storage	Resident Days	380,780	15	8,118		14,737	314	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		14,737	390	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,498,033	$ 2,068,642		$ 135,382	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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 St.
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	4	Laundry	Revenue	250,260	3	$ 201,274	$ 173,530	67,340	$ 54,159	1
2	5	Utilities	Revenue	250,260	3	29,766		67,340	8,009	2
3	6	Maintenance	Revenue	250,260	3	157,143	147,458	67,340	42,284	3
4	19	Professional Services	Revenue	250,260	3	2,823		67,340	760	4
5	21	Clerical & Office Supplies	Revenue	250,260	3	8,696		67,340	2,340	5
6	22	Payroll Taxes & Emp Ben.	Revenue	250,260	3	54,347		67,340	14,624	6
7	25	Other Admin Transp	Revenue	250,260	3	47,251		67,340	12,714	7
8	26	Insurance	Revenue	250,260	3	1,119		67,340	301	8
9	30	Depreciation	Revenue	250,260	3	13,843		67,340	3,725	9
10	33	Real Estate Taxes	Revenue	250,260	3	3,966		67,340	1,067	10
11	34	Rent - Facility	Revenue	250,260	3	7,980		67,340	2,147	11
12	35	Rent - Vehicle	Revenue	250,260	3	303		67,340	82	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					$ 528,511	$ 320,988		$ 142,212	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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: NW Rehab
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	10	Nursing & Med	Revenue	2,717,752	19	$ 792	$	2,318	$ 1	1
2	10a	Therapy	Revenue	2,717,752	19	1,870,778	1,870,778	2,318	1,596	2
3	17	Admin Salaries	Revenue	2,717,752	19	366,622	366,622	2,318	313	3
4	20	Dues & Subscriptions	Revenue	2,717,752	19	41		2,318		4
5	21	Clerical & Office Supplies	Revenue	2,717,752	19	30,294		2,318	26	5
6	22	Employee Benefits	Revenue	2,717,752	19	308,794		2,318	263	6
7	24	Travel & Seminar	Revenue	2,717,752	19	19,790		2,318	17	7
8	25	Other Admin Transp	Revenue	2,717,752	19	37,856		2,318	32	8
9	32	Interest	Revenue	2,717,752	19	28,025		2,318	24	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					$ 2,662,992	$ 2,237,400		$ 2,272	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	40,315	6
7												7
8	Related Party Allocation										24	8
9	TOTAL Facility Related						$	$			$ 40,339	9
	B. Non-Facility Related*											
10	Interest Income Offset										(4,097)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,097)	14
15	TOTALS (line 9+line14)						$	$			$ 36,242	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' PREPARATION 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 Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 7,820	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.)		$ 51,265	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43,445	3
4. Real Estate Tax accrual used for 2018 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.)		$ 7,812	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.		$ 51,257	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	32,936	8
2014	32,386	9
2015	7,301	10
2016	7,847	11
2017	7,635	12

51,257	Line 7, Real Estate Tax Portion of Lease Payments
29	Bridgemark Healthcare Allocation
1,067	Helia Healthcare Allocation
52,353	Total Schedule V, Line 33

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Frankfort Healthcare & Rehab Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0046268

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-20-402-009	SEC 20 TWP 07 PT NW SE	$ 7,634.88	$ 7,634.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,634.88	$ 7,634.88

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,759 B. General Construction Type: Exterior Brick Frame Block 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).

None

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		2006	$ 1,348	1
2					2
3	TOTALS			$ 1,348	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	Helia Healthcare Allocation		2006	2006	$ 35,932	$	20	$ 1,797	$ 1,797	$ 8,169	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	Heating and Air Conditoning			2004	4,055						10
11	Heating and Air Conditoning			2004	596						11
12	Heating and Air Conditoning			2004	416						12
13	Heating and Air Conditoning			2004	767						13
14	Monitor System			2006	772						14
15	Wander Guard			2006	1,400						15
16	ADT Fire Alarm System			2007	3,034						16
17	Windsor Lighting			2008	1,556						17
18	Carpeting			2008	953						18
19	Southside Lumber			2008	1,281						19
20	Heating and Air Conditoning			2008	665						20
21	Heating and Air Conditoning			2008	1,440						21
22	Call System & Cable Installation			2009	7,220						22
23	Wallcovering			2009	9,958						23
24	Carpeting			2009	1,170						24
25	Shed			2009	974						25
26	Outdoor Facility Signage			2010	2,667						26
27	Replace Door/System			2010	3,855						27
28	Sprinkler System Improvements			2010	32,932						28
29	Dining Room Tile, Paint, Hand Rails, Labor			2011	10,978						29
30	Family Room Paint, Flooring Cabinet, Sink, Labor			2011	8,782						30
31	Nurse's Station Remodel			2011	6,587						31
32	Beauty Shop Paint, Flooring Cabinet, Sink, Labor			2011	4,391						32
33	East Hallway Paint, Flooring, Hand Rails, Drywall, Labor			2011	6,801						33
34	West Hallway Paint, Flooring, Hand Rails, Drywall, Labor			2011	6,801						34
35	Shower Room Renovations - Tile, shower heads, fixtures, paint			2011	3,757						35
36	Interlocking Carpet			2011	2,618						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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	3 Fire Doors for POC	2012	$ 4,839	$		$	$	$	37
38	Replace Roof	2012	13,205						38
39	Arcoaire 5 Ton Package Unit	2012	5,580						39
40	Remodeling	2013	1,501						40
41									41
42	Bathroom Remodeling - Toilets, Showerheads, etc.	2014	976	98	10	98		447	42
43	Water Heater	2014	1,412	141	10	141		612	43
44	Room 16 East Hall - toilet, sink, floor, remodel	2014	1,465	147	10	147		635	44
45	Room 30 West Hall - drywall, floor, lighting, remodel	2014	852	85	10	85		362	45
46	Labor & Material for 5 Ton RTU	2014	5,864	586	10	586		2,443	46
47	Lights, Paint, Flooring for resident room A - Wing	2015	5,085	339	15	339		1,271	47
48	Sewage Pipe Replacement	2015	8,400	420	20	420		1,330	48
49	A/C Unit	2016	6,526	653	10	653		1,686	49
50	Roof Repairs	2017	3,790	379	10	379		948	50
51	A/C Rooftop Unit Replacement	2017	6,400	640	10	640		800	51
52	Replace 15 Dry Pendants	2018	3,584	131	25	131		131	52
53	Carpet	2018	1,069	89	5	89		89	53
54	5 ton Rooftop Unit - Cooling Only	2018	13,000	433	10	433		433	54
55	Install Junction Terminal Boxes	2018	1,501	38	10	38		38	55
56									56
57									57
58	Related Party Allocation - Bridgemark Healthcare LLC								58
59	New Office Build Out	2011	5,256		20	278	278	2,075	59
60	Conference Room Chair Rail & Paint	2012	59		5			59	60
61	AC Unit in Server Room	2018	408		20	10	10	10	61
62									62
63									63
64	Related Party Allocation - Helia Healthcare								64
65	Water & Sewer Pipe Installation	2006	511		20	26	26	318	65
66	Plumbing & Heating Installation	2006	612		20	31	31	380	66
67	400-Ton A/C	2007	1,475		10			1,475	67
68	400 Gal. Water Storage Tank	2016	4,161		10	416	416	1,006	68
69	AC Compressor at Martin's Catering Building	2018	673		15	22	22	22	69
70	TOTAL (lines 4 thru 69)		$ 260,562	$ 4,179		$ 6,759	$ 2,580	$ 24,739	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	$ 50,895	$ 4,436	$ 6,295	$ 1,859	3-15 Yrs	$ 19,288	71
72	Current Year Purchases	2,195	102	219	117	3-15 Yrs	219	72
73	Fully Depreciated Assets	19,131					19,131	73
74								74
75	TOTALS	$ 72,221	$ 4,538	$ 6,514	$ 1,976		$ 38,638	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	Related Party Allocation - Bridgemark		2005	$ 514	$	$	$	4	$ 514	76
77	Related Party Allocation - Helia		2006	1,806				4	1,806	77
78										78
79										79
80	TOTALS			$ 2,320	$	$	$		$ 2,320	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)	$ 336,451	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,717	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,273	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,556	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 65,697	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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG West Frankfort Property, LLC

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:		57	5/7/18	$ 244,205			3
4	Additions							4
5	Related Party Allocation				6,411			5
6								6
7	TOTAL		57		$ 250,616 **			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 5/7/18
Ending 4/30/38

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 15,701 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' PREPARATION REPORT

Frankfort Healthcare & Rehab Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2018

	Description	
16A	Nursing Equipment	6,464
16B	Copier Lease	304
16C	Related Party Allocations	472
16D	Dietary Equipment	685
16E	Respiratory Equipment	5,015
16F	Storage	1,080
16G	Computers & Software	1,681
		15,701

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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				288		288	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				75,131		75,131	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wount, Oxy, Enterals	39,2					11,349		11,349	12
13	Other (specify): X-Rays, Labs, Therapy	39,3				159,469			159,469	13
14	TOTAL			$		$ 159,469	$ 86,768		$ 246,237	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 3,997	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (135,000))	384,397		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,239,755		8
9	Other(specify): Deposits	1,579		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,629,728	$	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	57,010		15
16	Equipment, at Historical Cost	48,588		16
17	Accumulated Depreciation (book methods)	(31,499)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,812		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 81,911	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,711,639	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 426,386	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,782		30
31	Accrued Taxes Payable (excluding real estate taxes)	744		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,812		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	5,827		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 480,551	$	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	81,364		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 81,364	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 561,915	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,149,724	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,711,639	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,894,168	1
2	Restatements (describe):		2
3	**Prior Year adjustments after cost report submitted**	(377,859)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,516,309	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(366,585)	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)**	$ (366,585)	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)**	$ 1,149,724	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	$ 2,195,525	1
2	Discounts and Allowances for all Levels	(117,851)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,077,674	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,844	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 71,844	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,097	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,097	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Late Fee forgiveness	17,834	28
28a	Miscellaneous	997	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,831	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,172,446	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	481,253	31
32	Health Care	772,896	32
33	General Administration	549,455	33
	B. Capital Expense		
34	Ownership	359,723	34
	C. Ancillary Expense		
35	Special Cost Centers	248,267	35
36	Provider Participation Fee	127,437	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,539,031	40
41	**Income before Income Taxes (line 30 minus line 40)****	(366,585)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (366,585)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,231,629	44
45	Private Pay - Net Inpatient Revenue	212,222	45
46	Medicare - Net Inpatient Revenue	546,344	46
47	Other-(specify) Insurance	31,654	47
48	Other-(specify) Hospice	55,825	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,077,674	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' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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	1,193	1,263	$ 40,524	$ 32.09	1
2	Assistant Director of Nursing	2,467	2,739	75,655	27.62	2
3	Registered Nurses	5,606	6,108	164,960	27.01	3
4	Licensed Practical Nurses	3,132	3,267	73,664	22.55	4
5	CNAs & Orderlies	22,547	23,775	269,394	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,901	2,170	32,516	14.98	9
10	Activity Assistants					10
11	Social Service Workers	1,911	2,109	39,604	18.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,553	8,054	93,475	11.61	15
16	Dishwashers					16
17	Maintenance Workers	1,758	2,041	55,467	27.18	17
18	Housekeepers	4,882	5,287	49,126	9.29	18
19	Laundry	373	493	5,338	10.83	19
20	Administrator	2,005	2,136	81,232	38.03	20
21	Assistant Administrator					21
22	Other Administrative	631	700	24,111	34.44	22
23	Office Manager					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)	11	11	193	17.55	30
31	Medical Records	41	42	414	9.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	56,011	60,195	$ 1,005,673 *	$ 16.71	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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		$ 4,952	1,3	35
36	Medical Director		6,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,485	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		2,756	11,3	44
45	Social Service Consultant		1,703	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,896		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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan M. Williams	Administrator	0	$ 81,232
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,232

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 94,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 94,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting Fees	$ 2,175
Personnel Planners	Unemployement Consulting	1,743
Stein Law Offices	Legal Fees	1,038
Much Shelist, P.C.	Legal Fees	1,631
Heyl Royster	Legal Fees	8,312
Veritext Corp.	Legal Fees	443
Kramer & Frank	Collections - Eliminated	285
Paycom Payroll, LLC	Payroll Processing	6,467
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 22,094

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,328
Unemployment Compensation Insurance	14,065
FICA Taxes	76,676
Employee Health Insurance	19,670
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	1,463
Employee Benefits	807
Related Party Allocation - Bridgemark	9,887
Related Party Allocation - Helia	14,624
Related Party Allocation - NW Rehab	263
TOTAL (agree to Schedule V, line 22, col.8)	$ 141,783

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	3,709
Health Care Worker Background Check	1,185
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	4,650
Advertising	22,597
Miscellaneous Licenses & Fees	294
Related Party Allocation - Bridgemark	687
Less: Public Relations Expense	( )
Non-allowable advertising	(22,597)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,515

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	203
Seminar Expense	859
Related Party Allocation - Bridgemark	2,896
Related Party Allocation - NW Rehab	17
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,975

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 1/01/18 Ending: 12/31/18

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 $2,563**

(3) Did the nursing home make political contributions or payments to a politica
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? **No**

(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. $ **9,319** 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 fo
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 Departmen
during this cost report period. $ **127,437**
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' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo
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. $ **None** 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 fo
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 othe
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
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