		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0046268

Facility Name: Frankfort Hlthcare Rehab Ctr

Address: 2500 E St Louis St (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: 10/01/2003

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 01/01/2020 to 12/31/2020 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, 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' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,346	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,549	2,146	1,773	14,468	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,549	2,146	1,773	14,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.35%

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 1,419

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: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	101,123	7,497	4,738	113,358		113,358		113,358			1
2	Food Purchase		84,850		84,850		84,850	(62)	84,788			2
3	Housekeeping	66,109	17,138	3,961	87,208		87,208		87,208			3
4	Laundry		9,162	59,780	68,942		68,942	(16,135)	52,807			4
5	Heat and Other Utilities			40,353	40,353		40,353	(584)	39,769			5
6	Maintenance	37,818	12,000	31,233	81,051		81,051	41,954	123,005			6
7	Other (specify):*											7
8	**TOTAL General Services**	205,050	130,647	140,065	475,762		475,762	25,173	500,935			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	640,604	59,431	22,326	722,361		722,361	15,986	738,347			10
10a	Therapy		1,095		1,095		1,095		1,095			10a
11	Activities	31,729	2,797	1,709	36,235		36,235		36,235			11
12	Social Services	41,422		1,609	43,031		43,031		43,031			12
13	CNA Training											13
14	Program Transportation			516	516		516		516			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	713,755	63,323	32,160	809,238		809,238	15,986	825,224			16
	C. General Administration											
17	Administrative	81,311		139,900	221,211		221,211	(125,389)	95,822			17
18	Directors Fees											18
19	Professional Services			36,315	36,315		36,315	4,712	41,027			19
20	Dues, Fees, Subscriptions & Promotions			42,552	42,552		42,552	(29,408)	13,144			20
21	Clerical & General Office Expenses		6,691	78,952	85,643		85,643	74,857	160,500			21
22	Employee Benefits & Payroll Taxes			110,155	110,155		110,155	23,293	133,448			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,391	1,391		1,391	1,270	2,661			24
25	Other Admin. Staff Transportation			2,074	2,074		2,074	12,840	14,914			25
26	Insurance-Prop.Liab.Malpractice			235,479	235,479		235,479	13,010	248,489			26
27	Other (specify):*											27
28	**TOTAL General Administration**	81,311	6,691	646,818	734,820		734,820	(24,815)	710,005			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,000,116	200,661	819,043	2,019,820		2,019,820	16,344	2,036,164			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.

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			19,629	19,629		19,629	5,697	25,326			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,371	39,371		39,371	(142)	39,229			32
33	Real Estate Taxes			8,400	8,400		8,400	1,124	9,524			33
34	Rent-Facility & Grounds			330,885	330,885		330,885	4,559	335,444			34
35	Rent-Equipment & Vehicles			17,664	17,664		17,664	567	18,231			35
36	Other (specify):* Gain/Loss on Disposition			(10,648)	(10,648)		(10,648)		(10,648)			36
37	**TOTAL Ownership**			405,301	405,301		405,301	11,805	417,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,480	188,718	241,198		241,198		241,198			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,730	105,730		105,730		105,730			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		52,480	294,448	346,928		346,928		346,928			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,000,116	253,141	1,518,792	2,772,049		2,772,049	28,149	2,800,198			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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(7,948)	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	(142)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(62)	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	(1,956)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,988)	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	(2,402)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,648)		$	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)	68,797	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 68,797		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 28,149		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 Hlthcare Rehab Ctr

ID# 0046268

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (2,545)	20	1
2	To Eliminate Lobbying & PAC Dues	(1,402)	20	2
3	To Offset Medical Records Income	(113)	10	3
4	To Add IDPH Fee Paid in Prior Year	1,658	20	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
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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**	(2,402)		49

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. Ann, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Olney	Olney, IL	Bridgemark Employee	St. Ann, MO	Human Resources
		Palladian Senior Care of Poplar Blluff	Poplar Bluff, MO	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Energy	Energy, IL	Palladian Management	O'Fallon, IL	Management Co.
		Helia Southbelt Healthcare	Belleville, IL	Palladian Mt. Vernon A	Mt. Vernon, IL	Assisted Living
		Hillside Rehab & Care Center	Yorkville, IL	Palladian Taylorville A	Taylorville, IL	Assisted Living

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%	$ 288	$ 288	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	16,099	16,099	2
3	V	17	Management Fees	139,900	Bridgemark Healthcare, LLC	100.00%	14,511	(125,389)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	4,712	4,712	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	768	768	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	74,843	74,843	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	8,426	8,426	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	1,270	1,270	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	1,814	1,814	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	12,217	12,217	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,062	2,062	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	22	22	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	3,814	3,814	13
14	Total			$ 139,900			$ 140,846	$ * 946	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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%	$ 567	$ 567	15
16	V								16
17	V								17
18	V	4	Laundry	59,090	Helia Healthcare Services	100.00%	42,955	(16,135)	18
19	V	5	Utilities		Helia Healthcare Services	100.00%	7,076	7,076	19
20	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	44,954	41,954	20
21	V	20	Fees, Subscriptions, Promos		Helia Healthcare Services	100.00%	251	251	21
22	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,970	1,970	22
23	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	14,867	14,867	23
24	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	11,026	11,026	24
25	V	26	Insurance		Helia Healthcare Services	100.00%	793	793	25
26	V	30	Depreciation		Helia Healthcare Services	100.00%	3,635	3,635	26
27	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,102	1,102	27
28	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	745	745	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 62,090			$ 129,941	$ * 67,851	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Healthcare of Jerseyville	Jerseyville, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Effingham	Effingham, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Helia Richland Healthcare, LLC	Olney, IL				7
8			Helia Healthcare of Newton, LLC	Newton, IL				8
9			Palladian Aviston SNF, LLC	Aviston, IL				9
10			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				10
11			Palladian Taylorville SNF, LLC	Taylorville, IL				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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Stephen P. Miller	Owner	Administrative	100.00	391,917	1.79	3.57	Distribution	$ 14,511	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	$ 14,511		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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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	500 NW Plaza Dr., Suite 712
City / State / Zip Code	Saint Ann, MO 63074
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	405,225	17	$ 8,060	$	14,468	$ 288	1
2	10	Nursing & Medical Supplies	Resident Days	405,225	17	450,909	450,909	14,468	16,099	2
3	17	Owner's Compensation	Resident Days	405,225	17	406,428		14,468	14,511	3
4	19	Professional Fees	Resident Days	405,225	17	131,963		14,468	4,712	4
5	20	Dues, Subscriptions	Resident Days	405,225	17	21,510		14,468	768	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	14,468	59,363	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		14,468	15,480	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	405,225	17	235,995		14,468	8,426	8
9	24	Seminars	Resident Days	405,225	17	35,584		14,468	1,270	9
10	25	Admin Staff Travel	Resident Days	405,225	17	50,795		14,468	1,814	10
11	26	Insurance	Resident Days	405,225	17	342,172		14,468	12,217	11
12	30	Depreciation	Resident Days	405,225	17	57,762		14,468	2,062	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		14,468	22	13
14	34	Building Rent	Resident Days	405,225	17	97,672		14,468	3,487	14
15	34	Rental - Storage	Resident Days	405,225	17	9,163		14,468	327	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		14,468	567	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,960,735	$ 2,113,564		$ 141,413	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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	227,980	3	$ 157,720	$ 145,852	62,090	$ 42,955	1
2	5	Utilities	Revenue	227,980	3	25,982		62,090	7,076	2
3	6	Maintenance	Revenue	227,980	3	165,062	156,354	62,090	44,954	3
4	20	Dues, Fees & Subscriptions	Revenue	227,980	3	920		62,090	251	4
5	21	Clerical & Office Supplies	Revenue	227,980	3	7,235		62,090	1,970	5
6	22	Payroll Taxes & Emp Benefits	Revenue	227,980	3	54,589		62,090	14,867	6
7	25	Other Admin Transportation	Revenue	227,980	3	40,485		62,090	11,026	7
8	26	Insurance	Revenue	227,980	3	2,911		62,090	793	8
9	30	Depreciation	Revenue	227,980	3	13,347		62,090	3,635	9
10	33	Real Estate Taxes	Revenue	227,980	3	4,046		62,090	1,102	10
11	34	Rent - Facility	Revenue	227,980	3	2,736		62,090	745	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					$ 475,033	$ 302,206		$ 129,374	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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 IV Trust		X	Line of Credit		10/22/09				Variable	38,750	6
7	HFS		X			8/1/19					308	7
8	Medline		X			11/15/19				8.0000	313	8
9	TOTAL Facility Related						$	$			$ 39,371	9
	B. Non-Facility Related*											
10	Interest Income Offset										(142)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (142)	14
15	TOTALS (line 9+line14)						$	$			$ 39,229	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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description	Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 8,400	2
3. Under or (over) accrual (line 2 minus line 1).	$ 8,400	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ______ For ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 8,400	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	7,301	8
2016	7,847	9
2017	7,635	10
2018	8,073	11
2019	8,643	12

8,400 Line 7, Real Estate Tax Portion of Lease Payment
22 Bridgemark Healthcare Allocation
1,102 Helia Healthcare Allocation
9,524 Total Schedule V, Line 33

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2019 $	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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Frankfort Hlthcare Rehab Ctr COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0046268

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	12-20-402-009	SEC 20 TWP 07 PT NW SE	$ 8,642.58	$ 8,642.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,642.58	$ 8,642.58

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,759 B. General Construction Type: Exterior Brick Frame Blcok 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	$ 1,364	1
2					2
3	TOTALS			$ 1,364	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	$ 36,368	$	20	$ 1,818	$ 1,818	$ 11,905	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	Heating and Air Conditioning			2004	4,055						10
11	Heating and Air Conditioning			2004	596						11
12	Heating and Air Conditioning			2004	416						12
13	Heating and Air Conditioning			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 Conditioning			2008	665						20
21	Heating and Air Conditioning			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 Improvement			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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	3 Fire Doors for POC	2012	$ 4,389	$		$	$	$	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	Current Owner Additions								41
42	Bathroom Remodeling - Toilets, Showerheads, etc.	2014	976	98	10	98		642	42
43	Water Heater	2014	1,412	141	10	141		895	43
44	Room 16 East Hall - toilet, sink, floor, remodel	2014	1,465	147	10	147		928	44
45	Room 30 West Hall - drywall, floor, lighting, remodel	2014	852	85	10	85		532	45
46	Labor & Material for 5 Ton RTU	2014	5,864	586	10	586		3,616	46
47	Lights, Paint, Flooring for resident room A - Wing	2015	5,085	339	15	339		1,949	47
48	Sewage Pipe Replacement	2015	8,400	420	20	420		2,170	48
49	A/C Unit	2016	6,526	653	10	653		2,991	49
50	Roof Repairs	2017	3,790	379	10	379		1,706	50
51	A/C Rooftop Unit Replacement	2017	6,400	640	10	640		2,080	51
52	Replace 15 Dry Pendants	2018	3,584	143	25	143		418	52
53	Carpet	2018	1,069	214	5	214		517	53
54	5 ton Rooftop Unit - Cooling Only	2018	13,000	1,300	10	1,300		3,033	54
55	Install Junction Terminal Boxes	2018	1,501	150	10	150		338	55
56	Facility Roof Replacement - Disposed 2020	2019		1,247	10	1,247			56
57	Generator Installation fees	2019	6,650	1,330	5	1,330		2,328	57
58	Dell Wall Mounts	2019	3,212	321	10	321		321	58
59	Security Installed for 4 Exit Doors	2020	5,640	517	10	517		517	59
60	5 New RTU's	2020	23,250	969	10	969		969	60
61	New Generator	2020	35,617	2,374	5	2,374		2,374	61
62	Roof and Gutters	2020	42,008	2,801	10	2,801		2,801	62
63	Roofing, Soffit, Fascia, Gutters, etc.	2020	51,098	1,277	10	1,277		1,277	63
64									64
65	Related Party Allocations - Bridgemark Healthcare LLC								65
66	New Office Build Out	2011	4,849		20	257	257	2,427	66
67	Conference Room Chair Rail & Paint	2012	55		5			55	67
68	AC Unit in Server Room	2018	376		20	19	19	47	68
69									69
70	TOTAL (lines 4 thru 69)		$ 420,148	$ 16,131		$ 18,225	$ 2,094	$ 46,836	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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		$ 420,148	$ 16,131		$ 18,225	$ 2,094	$ 46,836	1
2	Related Party Allocations - Helia Healthcare								2
3	Water & Sewer Pipe Installation	2006	517		20	26	26	373	3
4	Plumbing & Heating Installation	2006	620		20	31	31	447	4
5	400 Gal. Water Storage Tank	2016	4,211		10	421	421	1,860	5
6	AC Compressor at Martin's Catering Building	2018	681		15	45	45	114	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	TOTAL (lines 1 thru 33)		$ 426,177	$ 16,131		$ 18,748	$ 2,617	$ 49,630	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 47,898	$ 3,456	$ 5,694	$ 2,238	3-15 Yrs	$ 24,214	71
72	Current Year Purchases	2,457	42	280	238	3-15 Yrs	280	72
73	Fully Depreciated Assets	12,316					12,316	73
74								74
75	TOTALS	$ 62,671	$ 3,498	$ 5,974	$ 2,476		$ 36,810	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				$	$	$	$		$	76
77	Related Party Allocation - Helia		2006	2,415		604	604	4	2,022	77
78										78
79										79
80	TOTALS			$ 2,415	$	$ 604	$ 604		$ 2,022	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)	$ 492,627	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,629	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,326	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,697	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 88,462	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.

SEE ACCOUNTANTS' PREPARATION REPORT

** This must agree with Schedule V line 30, column 8.

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. [ ] 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	$ 330,885			3
4	Additions							4
5								5
6								6
7	TOTAL		57		$ 330,885 **			7

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: *

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: $ 18,230 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
12/31/2020

	Description	
16A	Nursing Equipment	10,427
16B	Related Party Allocations	567
16C	Dietary Equipment	259
16D	Respiratory Equipment	2,731
16E	Storage	1,145
16F	Copier Lease	3,102
		18,231

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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				1,095		1,095	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				46,009		46,009	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					6,471		6,471	12
13	Other (specify): X-Rays, Labs, Therapy	39, 3				188,718			188,718	13
14	TOTAL			$		$ 188,718	$ 53,575		$ 242,293	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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 5,574	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (26,000))	336,579		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,407		7
8	Accounts Receivable (owners or related parties)	1,475,674		8
9	Other(specify): Deposits	1,579		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,824,813	$	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	224,485		15
16	Equipment, at Historical Cost	49,167		16
17	Accumulated Depreciation (book methods)	(59,954)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	1,979		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 215,677	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,040,490	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,222	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,921		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,491		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	6,586		36
37	Deferred CARES Funds	944,351		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,146,571	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	185,953		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)**	$ 267,317	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,413,888	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 626,602	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,040,490	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 725,960	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 725,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(99,358)	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)**	$ (99,358)	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)**	$ 626,602	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 2,704,336	1
2	Discounts and Allowances for all Levels	(161,229)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,543,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	62,164	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 62,164	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***	142	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 142	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	1,278	28
28a	CARES Funds	66,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 67,278	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,672,691	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	475,762	31
32	Health Care	809,238	32
33	General Administration	734,820	33
	B. Capital Expense		
34	Ownership	405,301	34
	C. Ancillary Expense		
35	Special Cost Centers	241,198	35
36	Provider Participation Fee	105,730	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,772,049	40
41	**Income before Income Taxes (line 30 minus line 40)****	(99,358)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (99,358)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,425,708	44
45	Private Pay - Net Inpatient Revenue	317,282	45
46	Medicare - Net Inpatient Revenue	710,549	46
47	Other-(specify) Insurance	45,367	47
48	Other-(specify) Hospice	44,201	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,543,107	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed 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 Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,243	2,404	$ 91,079	$ 37.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,963	3,244	97,537	30.07	3
4	Licensed Practical Nurses	6,648	6,875	159,307	23.17	4
5	CNAs & Orderlies	19,567	20,447	292,681	14.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,927	2,108	31,729	15.05	9
10	Activity Assistants					10
11	Social Service Workers	1,934	2,216	41,422	18.69	11
12	Dietician					12
13	Food Service Supervisor	1,819	2,088	34,894	16.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,694	5,947	66,229	11.14	15
16	Dishwashers					16
17	Maintenance Workers	1,895	1,994	37,818	18.97	17
18	Housekeepers	5,527	5,889	66,109	11.23	18
19	Laundry					19
20	Administrator	1,758	2,018	81,311	40.29	20
21	Assistant Administrator					21
22	Other Administrative					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)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	51,975	55,230	$ 1,000,116 *	$ 18.11	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 4,738	1, 3	35
36	Medical Director		6,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,296	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		1,709	11, 3	44
45	Social Service Consultant		1,609	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,352		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	40	1,491	10, 3	52
53	TOTAL (lines 50 - 52)	40	$ 1,491		53

Facility Name & ID Number: Frankfort Hlthcare Rehab Ctr # 0046268 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lana Younger	Administrator	0	$ 68,098
Tammy Williams	Administrator	0	13,213
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,311

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 139,900
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 139,900

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Planners	$ 2,441
Much Shelist	Legal Fees	2,543
Stein Law Offices	Legal Fees	6,809
Hamlin & Burton Liability Managem	Legal Fees	6,826
Franklin County Housing		75
Kramer & Frank PC	Legal Fees	1,355
C.J. Schlosser & Company, LLC	Accounting Services	4,000
Nationwide Trust	401k Admin	978
Pantegra	401k Admin	3,100
Paycom Payroll, LLC	Payroll Processing	8,188
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 36,315

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,465
Unemployment Compensation Insurance	6,696
FICA Taxes	74,806
Employee Health Insurance	10,717
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Match	1,476
Employee Benefits	827
Other Employee Insurance	168
Related Party Allocation - Bridgemark	8,426
Related Party Allocation - Helia	14,867
TOTAL (agree to Schedule V, line 22, col.8)	$ 133,448

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	3,090
Health Care Worker Background Check	1,116
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	2,228
IHCA Dues	2,976
Miscellaneous Licenses & Fees	725
Advertising	27,988
Related Party Allocations	1,019
Less: Public Relations Expense	( )
Non-allowable advertising	(27,988)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,144

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,391
Related Party Allocation - Bridgemark	1,270
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,661

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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 $2,976**

(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? **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. $ **11,278** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **105,730**
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 to the Department, in addition to the daily rate, been properly classified 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 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. $ **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 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.