

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

I. IDPH License ID Number: 0046268

Facility Name: Frankfort Healthcare & Rehab Center

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

County: Franklin

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

HFS ID Number: 510453700001

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Michael Parentin **Telephone Number:** (314) 431-0511

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) <u>Michael Parentin</u>	
	(Title) <u>Chief Financial Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>31</u>	Intermediate (ICF)	<u>31</u>	<u>11,315</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,913</u>	<u>2,058</u>	<u>3,262</u>	<u>10,233</u>	8
9	SNF/PED					9
10	ICF	<u>5,865</u>	<u>2,453</u>	<u>60</u>	<u>8,378</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,778</u>	<u>4,511</u>	<u>3,322</u>	<u>18,611</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.45%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/01/03

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/03 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 26 and days of care provided 3,121

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	91,240	15,837	5,544	112,621		112,621		112,621		1
2	Food Purchase		124,151		124,151	(6,580)	117,571	(301)	117,270		2
3	Housekeeping	72,702	18,743		91,445		91,445		91,445		3
4	Laundry	4,268	6,075	29,816	40,159		40,159	434	40,593		4
5	Heat and Other Utilities			37,022	37,022		37,022	9,715	46,737		5
6	Maintenance	25,460	13,112	35,394	73,966		73,966	18,130	92,096		6
7	Other (specify):*										7
8	TOTAL General Services	193,670	177,918	107,776	479,364	(6,580)	472,784	27,978	500,762		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	592,540	47,813	52	640,405		640,405	8,281	648,686		10
10a	Therapy			15	15		15		15		10a
11	Activities	25,950	4,775	5,273	35,998		35,998		35,998		11
12	Social Services	25,984	133	447	26,564		26,564		26,564		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							1,876	1,876		15
16	TOTAL Health Care and Programs	644,474	52,721	11,787	708,982		708,982	10,157	719,139		16
	C. General Administration										
17	Administrative	53,249		129,886	183,135		183,135	(129,886)	53,249		17
18	Directors Fees										18
19	Professional Services			19,899	19,899		19,899	5,327	25,226		19
20	Dues, Fees, Subscriptions & Promotions			14,944	14,944		14,944	(12,903)	2,041		20
21	Clerical & General Office Expenses	26,134	14,371	120,967	161,472		161,472	(40,584)	120,888		21
22	Employee Benefits & Payroll Taxes			169,634	169,634	6,580	176,214	3,717	179,931		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,177	9,177		9,177	(5,482)	3,695		24
25	Other Admin. Staff Transportation			5,344	5,344		5,344	7,621	12,965		25
26	Insurance-Prop.Liab.Malpractice			24,733	24,733		24,733	1,103	25,836		26
27	Other (specify):*							10,713	10,713		27
28	TOTAL General Administration	79,383	14,371	494,584	588,338	6,580	594,918	(160,374)	434,544		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	917,527	245,010	614,147	1,776,684		1,776,684	(122,239)	1,654,445		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center #0046268 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			10,370	10,370	10,370	814	11,184			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			4,607	4,607	4,607	486	5,093			32
33	Real Estate Taxes			24,300	24,300	24,300	6,885	31,185			33
34	Rent-Facility & Grounds			118,500	118,500	118,500	4,610	123,110			34
35	Rent-Equipment & Vehicles			3,322	3,322	3,322		3,322			35
36	Other (specify):*										36
37	TOTAL Ownership			161,099	161,099	161,099	12,795	173,894			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		105,042	345,489	450,531	450,531		450,531			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			31,208	31,208	31,208		31,208			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		105,042	376,697	481,739	481,739		481,739			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	917,527	350,052	1,151,943	2,419,522	2,419,522	(109,444)	2,310,078			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,406)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,489)	30		9
10	Interest and Other Investment Income	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(301)	02		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				17
18	Fines and Penalties				18
19	Entertainment	(5,601)	24		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	(93,139)	21		24
25	Fund Raising, Advertising and Promotional	(4,493)	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 See Attached	(11,172)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,648)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	11,204		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,204		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (109,444)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Frankfort Healthcare & Rehab Center

ID# 0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bank Charges	\$ (2,668)	21	1
2	Gifts and Flowers	(5,783)	20	2
3	Late Fees	(2,721)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,172)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/07

Ending:

12/31/07

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													1
2	Food Purchase	(301)											(301)	2
3	Housekeeping													3
4	Laundry				434								434	4
5	Heat and Other Utilities	(3,406)			13,121								9,715	5
6	Maintenance				18,130								18,130	6
7	Other (specify):*													7
8	TOTAL General Services	(3,707)			31,685								27,978	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			8,281									8,281	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,876									1,876	15
16	TOTAL Health Care and Programs			10,157									10,157	16
	C. General Administration													
17	Administrative			(129,886)									(129,886)	17
18	Directors Fees													18
19	Professional Services			5,327									5,327	19
20	Fees, Subscriptions & Promotions	(12,997)		94									(12,903)	20
21	Clerical & General Office Expenses	(95,807)		54,303	920								(40,584)	21
22	Employee Benefits & Payroll Taxes				3,717								3,717	22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,601)		119									(5,482)	24
25	Other Admin. Staff Transportation			2,535	5,086								7,621	25
26	Insurance-Prop.Liab.Malpractice			555	548								1,103	26
27	Other (specify):*			10,713									10,713	27
28	TOTAL General Administration	(114,405)		(56,240)	10,271								(160,374)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,112)		(46,083)	41,956								(122,239)	29

STATE OF ILLINOIS

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,489)		1,063	2,240								814	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(47)		15	518								486	32
33	Real Estate Taxes				6,885								6,885	33
34	Rent-Facility & Grounds			4,610									4,610	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(2,536)		5,688	9,643								12,795	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(120,648)		(40,395)	51,599								(109,444)	45

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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%	See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center# 0046268Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing & Med	\$	Bridgemark Healthcare, LLC	100.00%	\$ 8,281	\$ 8,281	15
16	V	15 Other Nursing		Bridgemark Healthcare, LLC	100.00%	1,876	1,876	16
17	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	5,327	5,327	17
18	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	94	94	18
19	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	54,303	54,303	19
20	V	24 Seminars		Bridgemark Healthcare, LLC	100.00%	119	119	20
21	V	25 Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	2,535	2,535	21
22	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	555	555	22
23	V	27 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	10,713	10,713	23
24	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,063	1,063	24
25	V	32 Interest		Bridgemark Healthcare, LLC	100.00%	15	15	25
26	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	4,550	4,550	26
27	V	34 Rental - Storage Unit		Bridgemark Healthcare, LLC	100.00%	60	60	27
28	V							28
29	V							29
30	V	17 Management Fees	129,886	Bridgemark Healthcare, LLC	100.00%		(129,886)	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		\$ 129,886			\$ 89,491	\$ * (40,395)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V	4	Laundry	\$ 29,816	Helia Healthcare Servcies	100.00%	\$ 30,250	\$ 434	15		
16	V	5	Utilities		Helia Healthcare Servcies	100.00%	13,121	13,121	16		
17	V	6	Repairs and Maintenance	3,000	Helia Healthcare Servcies	100.00%	21,130	18,130	17		
18	V	21	Clerical		Helia Healthcare Servcies	100.00%	920	920	18		
19	V	22	Employee Benefits		Helia Healthcare Servcies	100.00%	3,717	3,717	19		
20	V	25	Admin Staff Travel		Helia Healthcare Servcies	100.00%	5,086	5,086	20		
21	V	26	Insurance		Helia Healthcare Servcies	100.00%	548	548	21		
22	V	30	Depreciation		Helia Healthcare Servcies	100.00%	2,240	2,240	22		
23	V	32	Interest		Helia Healthcare Servcies	100.00%	518	518	23		
24	V	33	Real Estate Taxes		Helia Healthcare Servcies	100.00%	6,885	6,885	24		
25	V								25		
26	V								26		
27	V								27		
28	V								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			\$ 32,816			\$ 84,415	\$ * 51,599	39		

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	None								\$	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	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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 250
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 431-0511
 Fax Number (314) 754-9176

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing & Med	Resident Days	244,055	9	\$ 108,592	\$ 108,592	18,611	\$ 8,281	1
2	15	Other Nursing	Resident Days	244,055	9	24,600		18,611	1,876	2
3	19	Professional Fees	Resident Days	244,055	9	69,853		18,611	5,327	3
4	20	Dues, Subscriptions	Resident Days	244,055	9	1,232		18,611	94	4
5	21	Clerical	Resident Days	244,055	9	712,102	620,029	18,611	54,303	5
6	24	Seminars	Resident Days	244,055	9	1,558		18,611	119	6
7	25	Admin Staff Travel	Resident Days	244,055	9	33,238		18,611	2,535	7
8	26	Insurance	Resident Days	244,055	9	7,276		18,611	555	8
9	27	Employee Benefits	Resident Days	244,055	9	140,480		18,611	10,713	9
10	30	Depreciation	Resident Days	244,055	9	13,943		18,611	1,063	10
11	32	Interest	Resident Days	244,055	9	191		18,611	15	11
12	34	Rent	Resident Days	244,055	9	59,660		18,611	4,550	12
13	34	Rental - Storage Unit	Resident Days	244,055	9	781		18,611	60	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					\$ 1,173,506	\$ 728,621		\$ 89,491	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	Laundry	Revenue	102,812	4	\$ 94,774	\$ 72,978	32,816	\$ 30,250	1
2	5	Utilities	Revenue	102,812	4	41,109		32,816	13,121	2
3	6	Repairs and Maintenance	Revenue	102,812	4	66,200	56,287	32,816	21,130	3
4	21	Clerical	Revenue	102,812	4	2,881		32,816	920	4
5	22	Employee Benefits	Revenue	102,812	4	11,644		32,816	3,717	5
6	25	Admin Staff Travel	Revenue	102,812	4	15,933		32,816	5,086	6
7	26	Insurance	Revenue	102,812	4	1,716		32,816	548	7
8	30	Depreciation	Revenue	102,812	4	7,019		32,816	2,240	8
9	32	Interest	Revenue	102,812	4	1,624		32,816	518	9
10	33	Real Estate Taxes	Revenue	102,812	4	21,571		32,816	6,885	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					\$ 264,471	\$ 129,265		\$ 84,415	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Midwest Bank		X	Line of Credit		1/1/07				4,607	6									
7	Allocate Bridgemark		X							15	7									
8	Allocate Helia Healthcare Services									518	8									
9	TOTAL Facility Related						\$	\$		\$ 5,140	9									
B. Non-Facility Related*																				
10	Interest Income		X							(47)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (47)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 5,093	15									

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 Michael Parentin

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-20-402-009</u>	<u>Long Term Care</u>	\$ <u>29,955.32</u>	\$ <u>29,955.32</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>29,955.32</u>	\$ <u>29,955.32</u>

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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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. (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocate Helia Healthcare Services</u>		<u>2006</u>	<u>\$ 1,596</u>	1
2					2
3	TOTALS			\$ 1,596	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		Allocate Helia Health Services	2006	2006	\$ 9,512	\$ 475	35	\$ 476	\$ 1	\$ 872	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Allocate Helia Health Services		2007	1,708	95	20	85	(10)	123	9
10		Heating & Air Conditioning		2004	4,055	811	5	811	(0)	2,909	10
11		Heating & Air Conditioning		2004	596	119	5	119	(0)	408	11
12		Heating & Air Conditioning		2004	416	83	5	83	(0)	285	12
13		Heating & Air Conditioning		2004	767	256	5	153	(102)	788	13
14		Monitor System		2006	772	154	20	39	(116)	219	14
15		Wander Guards		2006	1,400	280	10	140	(140)	327	15
16		ADT Fire Alarm System		2007	1,658	118	10	166	47	118	16
17		ADT Fire Alarm System		2007	1,376	82	10	138	56	82	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 22,260	\$ 2,474		\$ 2,210	\$ (264)	\$ 6,130	70

SEE ACCOUNTANTS' COMPILATION 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: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 35,401	\$ 8,706	\$ 6,682	\$ (2,024)	10	\$ 25,389	71
72	Current Year Purchases	21,549	2,332	2,131	(201)	10	3,055	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 56,950	\$ 11,038	\$ 8,813	\$ (2,225)		\$ 28,444	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility			\$	\$	\$	\$		\$	76
77	Allocate Bridgemark		2005	601	161	161			519	77
78										78
79										79
80	TOTALS			\$ 601	\$ 161	\$ 161	\$		\$ 519	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)	\$ 81,407	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,673	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,184	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,489)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 35,093	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Marion Properties

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		\$ 118,500			3
4	Additions							4
5	Allocate Bridgemark				4,610			5
6								6
7	TOTAL		57		\$ 123,110			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,322 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			\$ _____	\$ _____	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	39-03	hrs	\$		\$ 111,635	\$		\$ 111,635	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			76,239			76,239	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			140,612	1,156		141,768	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				85,833		85,833	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					17,003	18,053		35,056	13
14	TOTAL			\$		\$ 345,489	\$ 105,042		\$ 450,531	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center# 0046268Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(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	\$ 18,351	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	454,025		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,727		5
6	Prepaid Insurance	384		6
7	Other Prepaid Expenses	2,040		7
8	Accounts Receivable (owners or related parties)	1,189,388		8
9	Other(specify): <u>See Attached Schedule</u>	49,610		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,716,525	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	52,186		16
17	Accumulated Depreciation (book methods)	(29,485)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,701	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,739,226	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,375	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,398		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,062		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,625		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	690,843		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,026,303	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,026,303	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 712,923	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,739,226	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 549,796	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 549,802	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	163,121	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)	\$ 163,121	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)	\$ 712,923	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,361,191	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,361,191	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	163,166	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 163,166	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***	47	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare Bad Debt Settlement Income	58,239	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 58,239	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,582,643	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	479,364	31
32	Health Care	708,982	32
33	General Administration	588,338	33
B. Capital Expense			
34	Ownership	161,099	34
C. Ancillary Expense			
35	Special Cost Centers	450,531	35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,419,522	40
41	Income before Income Taxes (line 30 minus line 40)**	163,121	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 163,121	43

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

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

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

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

Facility Name & ID Number **Frankfort Healthcare & Rehab Center**

0046268

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,976	1,976	\$ 44,017	\$ 22.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	11,143	11,561	193,140	16.71	4
5	CNAs & Orderlies	35,565	36,367	320,743	8.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	25,950	12.48	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	25,984	12.49	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,120	34,936	16.48	13
14	Head Cook	581	589	5,342	9.07	14
15	Cook Helpers/Assistants	6,109	6,204	50,962	8.21	15
16	Dishwashers					16
17	Maintenance Workers	1,889	1,889	25,460	13.48	17
18	Housekeepers	5,651	5,772	43,362	7.51	18
19	Laundry	2,560	2,615	33,608	12.85	19
20	Administrator	2,080	2,080	53,249	25.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,032	2,032	26,134	12.86	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)	2,080	2,080	34,640	16.66	33
34	TOTAL (lines 1 - 33)	77,866	79,444	\$ 917,527 *	\$ 11.55	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	135	\$ 5,544	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	1	52	10-03	39
40	Physical Therapy Consultant	1	15	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	106	5,273	11-03	44
45	Social Service Consultant	9	447	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	252	\$ 17,331		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			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sherry Johnson	Administrator	0.00	\$ 53,249	Workers' Compensation Insurance	\$ 47,038	IDPH License Fee	\$	
				Unemployment Compensation Insurance	27,394	Advertising: Employee Recruitment	380	
				FICA Taxes	69,976	Health Care Worker Background Check	1,012	
				Employee Health Insurance	27,924	(Indicate # of checks performed)		
				Employee Meals	6,580	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Gifts and Flowers	5,783	
				401(K) Match	1,019	Advertising	4,493	
						Allocate Bridgemark Healthcare	94	
						Dues and Subscriptions	555	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,249					
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	(10,276)	
Bridgemark Healthcare Services, LLC			\$ 129,886			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 129,886	TOTAL (agree to Schedule V, line 22, col.8)	\$ 179,931	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,041	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ceridian	Payroll Processing		\$ 4,576				Out-of-State Travel	\$
Ashman and Stein	Legal		207					
Craig and Craig	Legal		1,713					
Concepte of Illinois	Computer Services		343				In-State Travel	
FR&R Healthcare Consulting	Accounting		5,450					
Keane	Computer Services		1,277					
MDI Technologies	Computer Services		920				Seminar Expense	3,576
Sachnoff and Weaver	Legal		1,114					
Wrights Computer	Computer Services		576				Allocate Bridgemark Healthcare	119
eHealth Data Solutions	Computer Services		3,243					
Personnel Planners	Unemployment Consultant		480				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,899	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,695

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION 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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,135 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. _____
- (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. \$ 31,208
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.
- (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. \$ 6,580 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT