

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>9,516</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>31</u>	Intermediate (ICF)	<u>31</u>	<u>11,346</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>20,862</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>5,746</u>		<u>2,834</u>	<u>8,580</u>	8
9	SNF/PED					9
10	ICF	<u>6,850</u>	<u>3,579</u>	<u>86</u>	<u>10,515</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,596</u>	<u>3,579</u>	<u>2,920</u>	<u>19,095</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.53%

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 2,834

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	102,339	10,137	4,104	116,580		116,580		116,580		
2	Food Purchase		100,440		100,440		100,440	(95)	100,345		
3	Housekeeping	59,179	16,338		75,517		75,517		75,517		
4	Laundry	20,184	9,246	30,849	60,279		60,279	8,236	68,515		
5	Heat and Other Utilities			41,836	41,836		41,836	9,498	51,334		
6	Maintenance	32,959	19,339	32,777	85,075		85,075	527	85,602		
7	Other (specify):*										
8	TOTAL General Services	214,661	155,500	109,566	479,727		479,727	18,166	497,893		
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000		7,000		
10	Nursing and Medical Records	630,626	46,632	500	677,758		677,758	11,109	688,867		
10a	Therapy		1,359	323,544	324,903		324,903		324,903		
11	Activities	33,670	7,193	4,100	44,963		44,963		44,963		
12	Social Services	27,946	189	2,580	30,715		30,715		30,715		
13	CNA Training										
14	Program Transportation			161	161		161		161		
15	Other (specify):*										
16	TOTAL Health Care and Programs	692,242	55,373	337,885	1,085,500		1,085,500	11,109	1,096,609		
	C. General Administration										
17	Administrative	53,249		135,507	188,756		188,756	(120,577)	68,179		
18	Directors Fees										
19	Professional Services			17,451	17,451		17,451	2,999	20,450		
20	Dues, Fees, Subscriptions & Promotions			12,949	12,949		12,949	(6,721)	6,228		
21	Clerical & General Office Expenses	28,635	13,191	42,735	84,561		84,561	67,734	152,295		
22	Employee Benefits & Payroll Taxes			174,638	174,638		174,638	21,571	196,209		
23	Inservice Training & Education										
24	Travel and Seminar							424	424		
25	Other Admin. Staff Transportation			7,194	7,194		7,194	15,829	23,023		
26	Insurance-Prop.Liab.Malpractice			50,946	50,946		50,946	1,356	52,302		
27	Other (specify):*										
28	TOTAL General Administration	81,884	13,191	441,420	536,495		536,495	(17,385)	519,110		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	988,787	224,064	888,871	2,101,722		2,101,722	11,890	2,113,612		

*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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			9,283	9,283		9,283	4,822	14,105			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			245	245		245	920	1,165			32
33	Real Estate Taxes			31,022	31,022		31,022	3,098	34,120			33
34	Rent-Facility & Grounds			118,500	118,500		118,500	5,630	124,130			34
35	Rent-Equipment & Vehicles			6,997	6,997		6,997	197	7,194			35
36	Other (specify):*											36
37	TOTAL Ownership			166,047	166,047		166,047	14,667	180,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,865	16,889	124,754		124,754		124,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,294	31,294		31,294		31,294			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		107,865	48,183	156,048		156,048		156,048			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	988,787	331,929	1,103,101	2,423,817		2,423,817	26,557	2,450,374			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:

01/01/08

Ending:

12/31/08

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	(5,078)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(95)	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	(335)	21		18
19	Entertainment	(8,394)	21		19
20	Contributions	(50)	21		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	(3,745)	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	(3,448)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,145)		\$	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)	47,702		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 47,702		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 26,557		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.		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					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: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Gifts and Flowers	\$ (3,448)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(3,448)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(95)	0	0	0	0	0	0	0	0	0	0	(95)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	8,236	0	0	0	0	0	0	0	0	8,236	4
5	Heat and Other Utilities	(5,078)	58	14,518	0	0	0	0	0	0	0	0	9,498	5
6	Maintenance	0	0	527	0	0	0	0	0	0	0	0	527	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,173)	58	23,281	0	18,166	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	11,109	0	0	0	0	0	0	0	0	0	11,109	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	11,109	0	0	0	0	0	0	0	0	0	11,109	16
	C. General Administration													
17	Administrative	0	(120,577)	0	0	0	0	0	0	0	0	0	(120,577)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,391	608	0	0	0	0	0	0	0	0	2,999	19
20	Fees, Subscriptions & Promotions	(7,193)	336	136	0	0	0	0	0	0	0	0	(6,721)	20
21	Clerical & General Office Expenses	(8,779)	64,071	12,442	0	0	0	0	0	0	0	0	67,734	21
22	Employee Benefits & Payroll Taxes	0	15,176	6,395	0	0	0	0	0	0	0	0	21,571	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	381	43	0	0	0	0	0	0	0	0	424	24
25	Other Admin. Staff Transportation	0	7,667	8,162	0	0	0	0	0	0	0	0	15,829	25
26	Insurance-Prop.Liab.Malpractice	0	966	390	0	0	0	0	0	0	0	0	1,356	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(15,972)	(29,589)	28,176	0	(17,385)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,145)	(18,422)	51,457	0	11,890	29							

STATE OF ILLINOIS

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/08

Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,031	3,791	0	0	0	0	0	0	0	0	4,822	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	920	0	0	0	0	0	0	0	0	920	32
33	Real Estate Taxes	0	0	3,098	0	0	0	0	0	0	0	0	3,098	33
34	Rent-Facility & Grounds	0	5,630	0	0	0	0	0	0	0	0	0	5,630	34
35	Rent-Equipment & Vehicles	0	197	0	0	0	0	0	0	0	0	0	197	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	6,858	7,809	0	14,667	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(21,145)	(11,564)	59,266	0	26,557	45							

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		Bridgemark Healthcare	St. Louis	Management Co.
				Helia Healthcare Services	Benton	Laundry, Maint.
				Bridgemark Employer Services	St. Louis	Human Resources
				Bridgemark Medical Supply	St. Louis	Medical Supplies

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)	
1	V	10 Nursing & Medical Records	\$	Bridgemark Healthcare, LLC	100.00%	\$ 11,109	\$ 11,109	1
2	V	17 Management Fees	135,507	Bridgemark Healthcare, LLC	100.00%	14,930	(120,577)	2
3	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	2,391	2,391	3
4	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	336	336	4
5	V	21 Clerical		Bridgemark Healthcare, LLC	100.00%	64,071	64,071	5
6	V	22 Employee Benefits		Bridgemark Healthcare, LLC	100.00%	15,176	15,176	6
7	V	24 Seminars		Bridgemark Healthcare, LLC	100.00%	381	381	7
8	V	25 Admin Staff Travel		Bridgemark Healthcare, LLC	100.00%	7,667	7,667	8
9	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	966	966	9
10	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,031	1,031	10
11	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	197	197	11
12	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	5,630	5,630	12
13	V	5 Utilities		Bridgemark Healthcare, LLC	100.00%	58	58	13
14	Total		\$ 135,507			\$ 123,943	\$ * (11,564)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	4 Laundry	\$ 30,849	Helia Healthcare Services	100.00%	\$ 39,085	\$ 8,236	15
16	V	5 Utilities		Helia Healthcare Services	100.00%	14,518	14,518	16
17	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	3,527	527	17
18	V	19 Professional Services		Helia Healthcare Services	100.00%	608	608	18
19	V	21 Clerical & Office Supplies		Helia Healthcare Services	100.00%	12,442	12,442	19
20	V	22 Payroll Taxes & Employee Benefits		Helia Healthcare Services	100.00%	6,395	6,395	20
21	V	24 Travel & Seminar		Helia Healthcare Services	100.00%	43	43	21
22	V	25 Other Admin Transportation		Helia Healthcare Services	100.00%	8,162	8,162	22
23	V	26 Insurance		Helia Healthcare Services	100.00%	390	390	23
24	V	30 Depreciation		Helia Healthcare Services	100.00%	3,791	3,791	24
25	V	32 Interest		Helia Healthcare Services	100.00%	920	920	25
26	V	33 Real Estate Taxes		Helia Healthcare Services	100.00%	3,098	3,098	26
27	V	20 Dues, Fees, & Subscriptions		Helia Healthcare Services	100.00%	136	136	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		\$ 33,849			\$ 93,115	\$ * 59,266	39

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	Stephen P. Miller	Owner	Administrative	100.00	189,867	4	7.30	Distribution	\$ 14,930	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	\$ 14,930		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:

01/01/08

Ending: 12/31/08

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

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	10	Nursing & Medical Records	Resident Days	261,924	10	\$ 152,384	\$ 152,384	19,095	\$ 11,109	1
2	17	Owners Compensation	Resident Days	261,924	10	204,797	19,095	14,930		2
3	19	Professional Fees	Resident Days	261,924	10	32,797	19,095	2,391		3
4	20	Dues, Subscriptions	Resident Days	261,924	10	4,612	19,095	336		4
5	21	Clerical	Resident Days	261,924	10	878,862	815,418	19,095	64,071	5
6	22	Employee Benefits	Resident Days	261,924	10	208,169	19,095	15,176		6
7	24	Seminars	Resident Days	261,924	10	5,223	19,095	381		7
8	25	Admin Staff Travel	Resident Days	261,924	10	105,166	19,095	7,667		8
9	26	Insurance	Resident Days	261,924	10	13,246	19,095	966		9
10	30	Depreciation	Resident Days	261,924	10	14,145	19,095	1,031		10
11	35	Equipment Rental	Resident Days	261,924	10	2,700	19,095	197		11
12	34	Rent	Resident Days	261,924	10	75,492	19,095	5,504		12
13	34	Rental - Storage Unit	Resident Days	261,924	10	1,731	19,095	126		13
14	5	Utilities	Resident Days	261,924	10	797	19,095	58		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,700,121	\$ 967,802		\$ 123,943	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	137,437	4	\$ 158,696	\$ 115,204	33,849	\$ 39,085	1
2	5	Utilities	Revenue	137,437	4	58,949	33,849	33,849	14,518	2
3	6	Maintenance	Revenue	137,437	4	14,320	10,640	33,849	3,527	3
4	19	Professional Services	Revenue	137,437	4	2,470	33,849	33,849	608	4
5	21	Clerical & Office Supplies	Revenue	137,437	4	50,519	46,312	33,849	12,442	5
6	22	Payroll Taxes & Emp Ben.	Revenue	137,437	4	25,964	33,849	33,849	6,395	6
7	24	Travel & Seminar	Revenue	137,437	4	176	33,849	33,849	43	7
8	25	Other Admin Transp	Revenue	137,437	4	33,140	33,849	33,849	8,162	8
9	26	Insurance	Revenue	137,437	4	1,582	33,849	33,849	390	9
10	30	Depreciation	Revenue	137,437	4	15,395	33,849	33,849	3,791	10
11	32	Interest	Revenue	137,437	4	3,736	33,849	33,849	920	11
12	33	Real Estate Taxes	Revenue	137,437	4	12,579	33,849	33,849	3,098	12
13	20	Dues, Fees, & Subscriptions	Revenue	137,437	4	554	33,849	33,849	136	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					\$ 378,080	\$ 172,156		\$ 93,115	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/08 Ending: 12/31/08

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				245	6									
7											7									
8	Allocate Helia Healthcare Services									920	8									
9	TOTAL Facility Related						\$	\$		\$ 1,165	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 1,165	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 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 Cos

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of total 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 2007.

(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>31,021.90</u>	\$ <u>31,021.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>31,021.90</u>	\$ <u>31,021.90</u>

B. Real Estate Tax Cost Allocation:

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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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:01/01/08 Ending:12/31/08**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 11,759 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1C. 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).

NoneF. 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>\$ 4,816</u>	1
2					2
3	TOTALS			\$ 4,816	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocate Helia Health Services		2006	2006	\$ 39,628	\$	20	\$ 1,541	\$ 1,541	\$ 2,214	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Heating & Air Conditioning			2004	4,055	811	5	811		3,720	10
11	Heating & Air Conditioning			2004	596	119	5	119		527	11
12	Heating & Air Conditioning			2004	416	83	5	83		368	12
13	Heating & Air Conditioning			2004	767		3			767	13
14	Monitor System			2006	772	154	5	154		373	14
15	Wander Guards			2006	1,400	280	5	280		607	15
16	ADT Fire Alarm System			2007	1,658	237	7	237		355	16
17	ADT Fire Alarm System			2007	1,376	197	7	197		278	17
18	Windsor Lightning			2008	1,556	65	10	65		65	18
19	Carpeting			2008	953	48	5	48		48	19
20	Southside Lumber			2008	1,281	11	10	11		11	20
21	Heating & Air Conditioning			2008	665	78	5	78		78	21
22	Heating & Air Conditioning			2008	1,440	96	5	96		96	22
23											23
24	Allocation from Helia Healthcare Services:										
25	Water & Sewer Pipe Installation			2006	468		20	23	23	57	25
26	Plumbing & Heating Installation			2006	560		20	28	28	68	26
27	4-Ton A/C Unit			2007	1,350		10	135	135	225	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:

01/01/08

Ending:

12/31/08

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)	\$ 58,941	\$ 2,179		\$ 3,906	\$ 1,727	\$ 9,857	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: 01/01/08 Ending: 12/31/08

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	\$ 49,651	\$ 6,059	\$ 8,511	\$ 2,452	3-7	\$ 30,588	71
72	Current Year Purchases	9,591	812	1,054	242	5-15	1,054	72
73	Fully Depreciated Assets	5,291					5,291	73
74								74
75	TOTALS	\$ 64,533	\$ 6,871	\$ 9,565	\$ 2,694		\$ 36,933	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	BUS	2008	\$ 3,500	\$ 233	\$ 233		5	\$ 233	76
77	Bridgemark Healthcare		Various	1,234		144	144	5	641	77
78	Helia Healthcare		Various	1,284		257	257	5	666	78
79										79
80	TOTALS			\$ 6,018	\$ 233	\$ 634	\$ 401		\$ 1,540	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)	\$ 134,308	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,283	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,105	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,822	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,330	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

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

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

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	Bridgemark Healthcare				5,630			5
6								6
7	TOTAL		57		\$ 124,130			7

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 N/A N/A

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: \$ 7,194 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

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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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.

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/08 Ending: 12/31/08

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	10a-3	hrs	\$		\$ 121,070	\$ 24		\$ 121,094	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			56,989			56,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			145,485	1,335		146,820	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 prescripts				96,668		96,668	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab & X-Rays</u>	39-3				16,889			16,889	12
13	Other (specify): <u>WoundCare,Oxy,Ent</u>	39-2					11,197		11,197	13
14	TOTAL			\$		\$ 340,433	\$ 109,224		\$ 449,657	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: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 4,555	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>23,056</u>)	571,501		3
4	Supply Inventory (priced at)	1,876		4
5	Short-Term Investments			5
6	Prepaid Insurance	72		6
7	Other Prepaid Expenses	915		7
8	Accounts Receivable (owners or related parties)	1,009,474		8
9	Other(specify): <u>Deposits</u>	257		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,588,650	\$	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	2,234		15
16	Equipment, at Historical Cost	67,131		16
17	Accumulated Depreciation (book methods)	(38,768)		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)	\$ 30,597	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,619,247	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 229,645	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,309		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,908		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 271,862	\$	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	<u>Note Payable - Owner</u>	81,365		43
44	<u>Note Payable - Lessor</u>	403,581		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 484,946	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 756,808	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 862,439	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,619,247	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 712,923	1
2	Restatements (describe):		2
3	Miscellaneous	27	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 712,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	204,840	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) Settlement with Lessor	(55,351)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 149,489	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)	\$ 862,439	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: 01/01/08 Ending: 12/31/08

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	\$ 2,501,343	1
2	Discounts and Allowances for all Levels	(52,435)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,448,908	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,538	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 179,538	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***	211	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 211	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,628,657	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	479,727	31
32	Health Care	1,085,500	32
33	General Administration	536,495	33
B. Capital Expense			
34	Ownership	166,047	34
C. Ancillary Expense			
35	Special Cost Centers	124,754	35
36	Provider Participation Fee	31,294	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,423,817	40
41	Income before Income Taxes (line 30 minus line 40)**	204,840	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 204,840	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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:

01/01/08

Ending:

12/31/08

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	2,040	2,080	\$ 47,147	\$ 22.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	11,776	12,556	225,376	17.95	4
5	CNAs & Orderlies	29,727	31,517	321,735	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,491	3,703	33,670	9.09	9
10	Activity Assistants					10
11	Social Service Workers	2,056	2,080	27,946	13.44	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,178	17.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,275	7,508	66,161	8.81	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	32,959	15.85	17
18	Housekeepers	5,982	6,282	59,179	9.42	18
19	Laundry	2,195	2,299	20,184	8.78	19
20	Administrator	2,080	2,080	53,249	25.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	28,635	13.77	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 Ca Care Plan	2,031	2,063	36,368	17.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	74,893	78,408	\$ 988,787 *	\$ 12.61	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	100	\$ 4,104	01-03	35
36	Medical Director	Monthly	7,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	500	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	82	4,100	11-03	44
45	Social Service Consultant	52	2,580	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	244	\$ 18,284		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. N/A
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,985 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,294
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Frankfort Healthcare & Rehab Center
Attachment to Schedule VII A
Related Nursing Homes
12/31/2008

Helia Healthcare of Belleville
Helia Healthcare of Benton
Helia Healthcare of Carbondale
Helia Healthcare of Champaign
Helia Healthcare of Energy
Helia Healthcare of Urbana
Helia Healthcare of Greenville
Helia Southbelt Healthcare
Sangamon Care Center

Frankfort Healthcare & Rehab Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2008

Description	
Dish Machine	\$ 905
Copier Rental	3,275
Bridgemark Healthcare Allocation	197
Nursing Equipment	2,817
	<u>\$ 7,194</u>