

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,315	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,957	2,024	1,770	17,751	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,957	2,024	1,770	17,751	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.32%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 1,610

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	89,448	6,511	4,912	100,871		100,871		100,871		1
2	Food Purchase		89,953		89,953		89,953	(51)	89,902		2
3	Housekeeping	34,163	16,327	20,084	70,574		70,574		70,574		3
4	Laundry	34,224	1,346	43,698	79,268		79,268	(9,228)	70,040		4
5	Heat and Other Utilities			38,708	38,708		38,708	3,901	42,609		5
6	Maintenance	55,034	16,467	30,081	101,582		101,582	43,862	145,444		6
7	Other (specify):*										7
8	TOTAL General Services	212,869	130,604	137,483	480,956		480,956	38,484	519,440		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	664,775	62,220	16,178	743,173		743,173	16,082	759,255		10
10a	Therapy		522		522		522	899	1,421		10a
11	Activities	32,328	1,019	3,525	36,872		36,872	(18)	36,854		11
12	Social Services	38,250		2,127	40,377		40,377		40,377		12
13	CNA Training										13
14	Program Transportation			5,962	5,962		5,962		5,962		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	735,353	63,761	33,792	832,906		832,906	16,963	849,869		16
	C. General Administration										
17	Administrative	72,165		140,800	212,965		212,965	(102,433)	110,532		17
18	Directors Fees										18
19	Professional Services			11,200	11,200		11,200	12,051	23,251		19
20	Dues, Fees, Subscriptions & Promotions			62,914	62,914		62,914	(28,957)	33,957		20
21	Clerical & General Office Expenses		16,346	98,986	115,332		115,332	70,351	185,683		21
22	Employee Benefits & Payroll Taxes			145,308	145,308		145,308	25,387	170,695		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,164	1,164		1,164	4,450	5,614		24
25	Other Admin. Staff Transportation			7,307	7,307		7,307	13,184	20,491		25
26	Insurance-Prop.Liab.Malpractice			52,988	52,988		52,988	1,836	54,824		26
27	Other (specify):*										27
28	TOTAL General Administration	72,165	16,346	520,667	609,178		609,178	(4,131)	605,047		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,020,387	210,711	691,942	1,923,040		1,923,040	51,316	1,974,356		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center

#0046268

Report Period Beginning:

01/01/17

Ending:

12/31/17

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			8,288	8,288		8,288	4,264	12,552			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,333	51,333		51,333	(105)	51,228			32
33	Real Estate Taxes			(20,327)	(20,327)		(20,327)	1,051	(19,276)			33
34	Rent-Facility & Grounds			87,168	87,168		87,168	6,588	93,756			34
35	Rent-Equipment & Vehicles			21,431	21,431		21,431	668	22,099			35
36	Other (specify):*											36
37	TOTAL Ownership			147,893	147,893		147,893	12,466	160,359			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,169	211,270	274,439		274,439	(1,440)	272,999			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			120,812	120,812		120,812		120,812			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		63,169	332,082	395,251		395,251	(1,440)	393,811			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,020,387	273,880	1,171,917	2,466,184		2,466,184	62,342	2,528,526			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(18)	11		4
5	Telephone, TV & Radio in Resident Rooms	(4,288)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(118)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(51)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(24,932)	21		18
19	Entertainment	(1,696)	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	(24,216)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,131)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,650)		\$	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)	122,992	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 122,992		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 62,342		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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' PREPARATION REPORT

Frankfort Healthcare & Rehab Center

ID# 0046268

Report Period Beginning: 01/01/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Eliminate Gifts & Flowers	\$	(4,001)	20 1
2	Eliminate Lobbying & PAC Dues		(1,130)	20 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		(5,131)	20 49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Greenville	Greenville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Energy	Energy, IL	Mid-South Health Clin	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 154	\$	154	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	16,082		16,082	2
3	V	17 Management Fees	140,800	Bridgemark Healthcare, LLC	100.00%	38,136		(102,664)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	10,876		10,876	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	540		540	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	95,249		95,249	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	13,749		13,749	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	4,441		4,441	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,557		4,557	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,311		1,311	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,025		1,025	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	13		13	12
13	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	4,851		4,851	13
14	Total		\$ 140,800			\$ 190,984	\$ *	50,184	14

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

SEE ACCOUNTANTS' PREPARATION 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	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	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 456	\$ 456	15
16	V								16
17	V	4	Laundry	42,600	Helia Healthcare Services	100.00%	33,372	(9,228)	17
18	V	5	Utilities		Helia Healthcare Services	100.00%	8,035	8,035	18
19	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	46,862	43,862	19
20	V	19	Professional Services		Helia Healthcare Services	100.00%	1,175	1,175	20
21	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,763	1,763	21
22	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	11,477	11,477	22
23	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	8,601	8,601	23
24	V	26	Insurance		Helia Healthcare Services	100.00%	523	523	24
25	V	30	Depreciation		Helia Healthcare Services	100.00%	3,239	3,239	25
26	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	1,038	1,038	26
27	V	34	Rent - Facility & Grounds		Helia Healthcare Services	100.00%	1,737	1,737	27
28	V	35	Rent - Vehicle		Helia Healthcare Services	100.00%	212	212	28
29	V								29
30	V	10a	Therapy		NW Rehab, LLC	100.00%	899	899	30
31	V	17	Administrative		NW Rehab, LLC	100.00%	231	231	31
32	V	21	Clerical & General Office Expense		NW Rehab, LLC	100.00%	17	17	32
33	V	22	Employee Benefits		NW Rehab, LLC	100.00%	161	161	33
34	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	9	9	34
35	V	25	Other Admin. Staff Transp.		NW Rehab, LLC	100.00%	26	26	35
36	V	26	Insurance - Prop Liab. Malprac		NW Rehab, LLC	100.00%	2	2	36
37	V	32	Interest		NW Rehab, LLC	100.00%	13	13	37
38	V	39	Ancillary Service Centers	1,440	NW Rehab, LLC	100.00%		(1,440)	38
39	Total		\$ 47,040				\$ 119,848	\$ * 72,808	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Florissant	Florissant, MO				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

Facility Name & ID Number Frankfort Healthcare & Rehab Center # 0046268 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	738,652	2.45	4.91	Distribution	\$ 38,136	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	\$ 38,136		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 100
 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	5	Utilities	Resident Days	361,568	13	\$ 3,142	\$ 17,751	\$ 154	1	
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	17,751	16,082	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788	17,751	38,136	3	
4	19	Professional Fees	Resident Days	361,568	13	221,539	17,751	10,876	4	
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991	17,751	540	5	
6	21	Salaries - Other	Resident Days	361,568	13	1,561,132	1,561,132	17,751	76,643	6
7	21	Clerical & Office Supplies	Resident Days	361,568	13	378,982	17,751	18,606	7	
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058	17,751	13,749	8	
9	24	Seminars	Resident Days	361,568	13	90,455	17,751	4,441	9	
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816	17,751	4,557	10	
11	26	Insurance	Resident Days	361,568	13	26,710	17,751	1,311	11	
12	30	Depreciation	Resident Days	361,568	13	20,874	17,751	1,025	12	
13	33	Real Estate Taxes	Resident Days	361,568	13	270	17,751	13	13	
14	34	Building Rent	Resident Days	361,568	13	95,731	17,751	4,700	14	
15	34	Rental - Storage	Resident Days	361,568	13	3,073	17,751	151	15	
16	35	Equipment Rental	Resident Days	361,568	13	9,287	17,751	456	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,899,417	\$ 1,888,701	\$ 191,440	25	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 Mcleansboro St
 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	178,000	3	\$ 130,267	\$ 130,267	45,600	\$ 33,372	1
2	5	Utilities	Revenue	178,000	3	31,363		45,600	8,035	2
3	6	Maintenance	Revenue	178,000	3	182,925	182,925	45,600	46,862	3
4	19	Professional Services	Revenue	178,000	3	4,588		45,600	1,175	4
5	21	Clerical & Office Supplies	Revenue	178,000	3	6,882		45,600	1,763	5
6	22	Payroll Taxes & Emp Benefits	Revenue	178,000	3	44,799		45,600	11,477	6
7	25	Other Admin Transportation	Revenue	178,000	3	33,574		45,600	8,601	7
8	26	Insurance	Revenue	178,000	3	2,042		45,600	523	8
9	30	Depreciation	Revenue	178,000	3	12,642		45,600	3,239	9
10	33	Real Estate Taxes	Revenue	178,000	3	4,052		45,600	1,038	10
11	34	Rent - Facility	Revenue	178,000	3	6,780		45,600	1,737	11
12	35	Rent - Vehicle	Revenue	178,000	3	829		45,600	212	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					\$ 460,743	\$ 313,192		\$ 118,034	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 NW Rehab, LLC
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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	10a	Therapy	Revenue	2,581,783	19	\$ 1,610,941	\$ 1,440	\$ 899	1
2	17	Admin Salaries	Revenue	2,581,783	19	414,064	1,440	231	2
3	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456	1,440	17	3
4	22	Employee Benefits	Revenue	2,581,783	19	288,251	1,440	161	4
5	24	Travel & Seminar	Revenue	2,581,783	19	16,377	1,440	9	5
6	25	Other Admin Transp	Revenue	2,581,783	19	46,860	1,440	26	6
7	26	Insurance - Prop Liab, Malprac	Revenue	2,581,783	19	3,500	1,440	2	7
8	32	Interest	Revenue	2,581,783	19	22,721	1,440	13	8
9	10	Nursing & Med	Revenue	2,581,783	19	73	1,440		9
10	20	Dues & Subscriptions	Revenue	2,581,783	19	136	1,440		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,433,379	\$ 2,025,005	\$ 1,358	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09					Variable	51,333	6					
7													7					
8	Related Party Allocation											13	8					
9	TOTAL Facility Related						\$	\$			\$	51,346	9					
B. Non-Facility Related*																		
10	Interest Income Offset											(118)	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(118)	14					
15	TOTALS (line 9+line14)						\$	\$			\$	51,228	15					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	35,994	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	7,847	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(28,147)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	7,820	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	(20,327)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	32,721	8
	2013	32,936	9
	2014	32,386	10
	2015	7,301	11
	2016	7,847	12

(20,327) Line 7, Real Estate Tax Portion of Lease Payments

13 Bridgemark Healthcare Allocation

1,038 Helia Healthcare Allocation

(19,276) Total Schedule V, Line 33

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Related Party Allocation - Helia Healthcare, 2006, \$ 1,283, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), (blank), \$ 1,283, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Helia Healthcare Allocation	2006	2006	\$ 34,209	\$	20	\$ 1,711	\$ 1,711	\$ 6,067	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Prior Owner Costs:									
10	Heating and Air Conditioning		2004	4,055						9
11	Heating and Air Conditioning		2004	596						10
12	Heating and Air Conditioning		2004	416						11
13	Heating and Air Conditioning		2004	767						12
14	Monitor System		2006	772						13
15	Wander Guard		2006	1,400						14
16	ADT Fire Alarm System		2007	3,034						15
17	Windsor Lighting		2008	1,556						16
18	Carpeting		2008	953						17
19	Southside Lumber		2008	1,281						18
20	Heating and Air Conditioning		2008	665						19
21	Heating and Air Conditioning		2008	1,440						20
22	Call System & Cable Installation		2009	7,220						21
23	Wallcovering		2009	9,958						22
24	Carpeting		2009	1,170						23
25	Shed		2009	974						24
26	Outdoor Facility Signage		2010	2,667						25
27	Replace Door/System		2010	3,855						26
28	Sprinkler System Improvements		2010	32,932						27
29	Dining Room Tile, Paint, Hand Rails, Labor		2011	10,978						28
30	Family Room Paint, Flooring Cabinet, Sink, Labor		2011	8,782						29
31	Nurse's Station Remodel		2011	6,587						30
32	Beauty Shop Paint, Flooring, Cabinet, Sink, Labor		2011	4,391						31
33	East Hallway Paint, Flooring, Hand Rails, Drywall, Labor		2011	6,801						32
34	West Hallway Paint, Flooring, Hand Rails, Drywall, Labor		2011	6,801						33
35	Shower Room Renovations - Tile, shower heads, fixtures, paint		2011	3,757						34
36	Interlocking Carpet		2011	2,618						35

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	3 Fire Doors for POC	2012	\$ 4,839	\$		\$	\$	\$	37
38	Replace Roof	2012	13,205						38
39	Arcoaire 5 Ton Package Unit	2012	5,580						39
40	Remodeling	2013	1,501						40
41									41
42	Bathroom Remodeling - Toilets, showerheads, etc.	2014	976	97	10	97		350	42
43	Water Heater	2014	1,412	141	10	141		471	43
44	Room 16 East Hall - toilet, sink, floor, remodel	2014	1,465	147	10	147		488	44
45	Room 30 West Hall - drywall, floor, lighting, remodel,	2014	852	85	10	85		277	45
46	Labor & Material for 5 Ton RTU	2014	5,864	586	10	586		1,857	46
47	Lights, Paint, Flooring for resident room A -Wing	2015	5,085	339	15	339		932	47
48	Sewage Pipe Replacement	2015	8,400	420	20	420		910	48
49	A/C Unit	2016	6,526	653	10	653		1,033	49
50	Roof Repairs	2016	3,790	379	10	379		569	50
51	A/C Rooftop Unit Replacement	2017	6,400	160	10	160		160	51
52									52
53									53
54									54
55									55
56	Related Party Allocation - Bridgemark Healthcare LLC								56
57	New Office Build-Out	2011	6,668		20	353	353	2,279	57
58	Conference Room Chair Rail & Paint	2012	75		5	10	10	75	58
59									59
60									60
61	Related Party Allocation - Helia Healthcare								61
62	Water & Sewer Pipe Installation	2006	487		20	24	24	278	62
63	Plumbing & Heating Installation	2006	583		20	29	29	333	63
64	4-Ton A/C	2007	1,404		10	47	47	1,404	64
65	400 Gal. Water Storage Tank	2016	3,961		10	396	396	561	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 239,708	\$ 3,007		\$ 5,577	\$ 2,570	\$ 18,044	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 44,850	\$ 4,801	\$ 6,282	\$ 1,481	3-15 Yrs	\$ 20,155	71
72	Current Year Purchases	13,900	480	693	213	3-15 Yrs	693	72
73	Fully Depreciated Assets	12,385					12,385	73
74								74
75	TOTALS	\$ 71,135	\$ 5,281	\$ 6,975	\$ 1,694		\$ 33,233	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party Allocation - Bridgemark		2005	\$ 652	\$	\$	\$	4	\$ 652	76
77	Related Party Allocation - Helia		2006	1,719				4	1,719	77
78										78
79										79
80	TOTALS			\$ 2,371	\$	\$	\$		\$ 2,371	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)	\$ 314,497	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,288	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,552	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,264	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 53,648	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>57</u>		\$ <u>87,168</u>			3
4	Additions							4
5	<u>Related Party Allocation</u>				<u>6,588</u>			5
6								6
7	TOTAL		57		\$ 93,756			7

10. Effective dates of current rental agreement:

Beginning 12/20/13

Ending 12/19/23

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2018</u>	\$ <u>84,000</u>
13.	<u>/2019</u>	\$ <u>84,000</u>
14.	<u>/2020</u>	\$ <u>84,000</u>

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: \$ 22,099 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	<u>Section N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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,2	hrs	\$		\$	18		\$	18	1	
2	Licensed Speech and Language Development Therapist		hrs								2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10a,2	hrs				504			504	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39,2	# of prescrpts				51,228			51,228	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39,2					11,941			11,941	12	
13	Other (specify): <u>X-Rays, Labs, Therapy</u>	39,3					211,270			211,270	13	
14	TOTAL			\$		\$	211,270	\$	63,691	\$	274,961	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,774	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	923,985		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,370,543		8
9	Other(specify): <u>Deposits</u>	22,579		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,320,881	\$	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	39,357		15
16	Equipment, at Historical Cost	45,747		16
17	Accumulated Depreciation (book methods)	(22,783)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	90,737		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 153,058	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,473,939	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 433,801	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,290		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,148		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,820		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	11,348		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 498,407	\$	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>	81,364		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 81,364	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 579,771	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,894,168	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,473,939	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,533,402	1
2	Restatements (describe):		2
3	Prior Year Adjustments made after Cost Report Issued	(3,452)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,529,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	364,218	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)	\$ 364,218	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,894,168	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning: 01/01/17

Ending:

12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,761,749	1
2	Discounts and Allowances for all Levels	(13,700)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,748,049	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,280	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 68,280	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	18	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)	\$ 18	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	118	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 118	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	13,937	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,937	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,830,402	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	480,956	31
32	Health Care	832,906	32
33	General Administration	609,178	33
B. Capital Expense			
34	Ownership	147,893	34
C. Ancillary Expense			
35	Special Cost Centers	274,439	35
36	Provider Participation Fee	120,812	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,466,184	40
41	Income before Income Taxes (line 30 minus line 40)**	364,218	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 364,218	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,700,994	44
45	Private Pay - Net Inpatient Revenue	273,240	45
46	Medicare - Net Inpatient Revenue	718,964	46
47	Other-(specify) <u>Insurance</u>	54,030	47
48	Other-(specify) <u>Hospice</u>	820	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,748,049	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1,933	2,192	\$ 69,087	\$ 31.52	1
2	Assistant Director of Nursing	1,769	1,886	50,706	26.89	2
3	Registered Nurses	3,706	4,072	105,244	25.85	3
4	Licensed Practical Nurses	5,835	6,111	127,677	20.89	4
5	CNAs & Orderlies	26,398	28,353	312,061	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,942	2,241	32,328	14.43	9
10	Activity Assistants					10
11	Social Service Workers	1,889	2,081	38,250	18.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,625	8,010	89,448	11.17	15
16	Dishwashers					16
17	Maintenance Workers	3,669	3,669	55,034	15.00	17
18	Housekeepers	3,504	3,758	34,163	9.09	18
19	Laundry	3,022	3,445	34,224	9.93	19
20	Administrator	1,786	1,934	72,165	37.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	63,078	67,752	\$ 1,020,387 *	\$ 15.06	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	\$ 4,912	1,3	35
36	Medical Director	6,000	9,3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	605	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	3,525	11,3	44
45	Social Service Consultant	2,127	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,169		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' PREPARATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$2,632
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,279 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 12/20/13
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 120,812
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18
- (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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Frankfort Healthcare & Rehab Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2017

Description		
16A	Nursing Equipment	4,933
16B	Copier Lease	606
16C	Related Party Allocations	668
16D	Dietary Equipment	545
16E	Respiratory Equipment	3,621
16F	Storage	1,080
16G	Computers & Software	10,646
		<u>22,099</u>