

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0046268</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER											
Facility Name: <u>Frankfort Healthcare & Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.											
Address: <u>2500 East St. Louis Street</u> <u>West Frankfort</u> <u>62896</u>													
Number City Zip Code													
County: <u>Franklin</u>													
Telephone Number: <u>(618) 932-3236</u> Fax # <u>(618) 937-1171</u>													
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Michael Parentin</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td>(Signed) <u>See Accountant's Compilation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Cindy A. Tefteller</u></td></tr><tr><td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u></td></tr><tr><td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Michael Parentin</u>	(Title) <u>Chief Financial Officer</u>	(Signed) <u>See Accountant's Compilation Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
Officer or Administrator of Provider	(Signed) _____												
	(Type or Print Name) <u>Michael Parentin</u>												
	(Title) <u>Chief Financial Officer</u>												
	(Signed) <u>See Accountant's Compilation Report</u>												
Paid Preparer	(Date) _____												
	(Print Name and Title) <u>Cindy A. Tefteller</u>												
	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>												
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>												
Date of Initial License for Current Owners: <u>10/01/03</u>													
Type of Ownership:													

Facility Name & ID Number Frankfort Healthcare & Rehab Center

0046268 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,120</u>	<u>3,834</u>	<u>2,123</u>	<u>16,077</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,105	15,105		15,105	5,479	20,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,600	2,600		2,600	16,033	18,633			32
33	Real Estate Taxes			24,300	24,300		24,300	3,027	27,327			33
34	Rent-Facility & Grounds			118,500	118,500		118,500	6,987	125,487			34
35	Rent-Equipment & Vehicles			7,931	7,931		7,931	160	8,091			35
36	Other (specify):*											36
37	TOTAL Ownership			168,436	168,436		168,436	31,686	200,122			

Report Period Beginning:

Ending:

ID#0046268

01/01/11

12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Eliminate Gifts & Flowers	\$ (5,775)	20	1
2	Eliminate Lobbying & PAC Dues	(1,386)	20	2
3	Offset Medical Records Income	(202)	10	3
4				4
5				5
6				6
7				7
8				8
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