



Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr

# 0046268 Report Period Beginning: 01/01/15 Ending: 12/31/15

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>8,665</u>	<u>1,999</u>	<u>2,319</u>	<u>12,983</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,665</u>	<u>1,999</u>	<u>2,319</u>	<u>12,983</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.40%

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 1,774

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: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

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
	<b>A. General Services</b>										
1	Dietary	77,293	7,207	4,816	89,316		89,316		89,316		1
2	Food Purchase		73,384		73,384		73,384	(56)	73,328		2
3	Housekeeping	56,294	13,890	8,773	78,957		78,957		78,957		3
4	Laundry	17,624	15,044	55,703	88,371		88,371		88,371		4
5	Heat and Other Utilities			33,562	33,562		33,562	(2,808)	30,754		5
6	Maintenance	51,787	15,056	48,210	115,053		115,053	3,869	118,922		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	202,998	124,581	151,064	478,643		478,643	1,005	479,648		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	559,197	43,154	23,036	625,387		625,387	6,843	632,230		10
10a	Therapy		157		157		157		157		10a
11	Activities	28,824	7,382	3,651	39,857		39,857	(10)	39,847		11
12	Social Services	37,756		1,871	39,627		39,627		39,627		12
13	CNA Training										13
14	Program Transportation			3,592	3,592		3,592		3,592		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	625,777	50,693	38,150	714,620		714,620	6,833	721,453		16
	<b>C. General Administration</b>										
17	Administrative	75,260		109,000	184,260		184,260	(97,279)	86,981		17
18	Directors Fees										18
19	Professional Services			13,000	13,000		13,000	3,423	16,423		19
20	Dues, Fees, Subscriptions & Promotions			66,290	66,290		66,290	(50,845)	15,445		20
21	Clerical & General Office Expenses	20,572	12,448	56,551	89,571		89,571	68,561	158,132		21
22	Employee Benefits & Payroll Taxes			162,295	162,295		162,295	21,878	184,173		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,350	1,350		1,350	2,600	3,950		24
25	Other Admin. Staff Transportation			9,375	9,375		9,375	11,794	21,169		25
26	Insurance-Prop.Liab.Malpractice			42,428	42,428		42,428	1,974	44,402		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	95,832	12,448	460,289	568,569		568,569	(37,894)	530,675		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	924,607	187,722	649,503	1,761,832		1,761,832	(30,056)	1,731,776		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr

#0046268

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	
	<b>D. Ownership</b>											
30	Depreciation			5,743	5,743	5,743	2,217	7,960				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,108	35,108	35,108	(334)	34,774				32
33	Real Estate Taxes			36,050	36,050	36,050	396	36,446				33
34	Rent-Facility & Grounds			86,106	86,106	86,106	6,239	92,345				34
35	Rent-Equipment & Vehicles			3,191	3,191	3,191	323	3,514				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			166,198	166,198	166,198	8,841	175,039				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,033	172,812	270,845	270,845		270,845				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,139	97,139	97,139		97,139				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		98,033	269,951	367,984	367,984		367,984				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	924,607	285,755	1,085,652	2,296,014	2,296,014	(21,215)	2,274,799				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 Hlthcr & Rehab Ctr

# 0046268

Report Period Beginning: 01/01/15

Ending: 12/31/15

**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	(10)	11		4
5	Telephone, TV & Radio in Resident Rooms	(4,224)	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	(334)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,491)	21		19
20	Contributions	(1,544)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(25)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(40,593)	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	(10,545)	20		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (59,972)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	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)	38,757	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 38,757		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (21,215)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Frankfort Hlthcr & Rehab Ctr

ID# 0046268

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts & Flowers	\$ (9,270)	20	1
2	Eliminate Lobbying & PAC Dues	(1,275)	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	<b>Total</b>		(10,545)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr# 0046268

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(56)	0	0	0	0	0	0	0	0	0	0	(56)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,224)	26	1,390	0	0	0	0	0	0	0	0	(2,808)	5
6	Maintenance	0	0	3,869	0	0	0	0	0	0	0	0	3,869	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,280)</b>	<b>26</b>	<b>5,259</b>	<b>0</b>	<b>1,005</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,843	0	0	0	0	0	0	0	0	0	6,843	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	<b>TOTAL Health Care and Programs</b>	<b>(10)</b>	<b>6,843</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6,833</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(97,279)	0	0	0	0	0	0	0	0	0	(97,279)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25)	2,822	626	0	0	0	0	0	0	0	0	3,423	19
20	Fees, Subscriptions & Promotions	(51,288)	443	0	0	0	0	0	0	0	0	0	(50,845)	20
21	Clerical & General Office Expenses	(4,035)	71,688	908	0	0	0	0	0	0	0	0	68,561	21
22	Employee Benefits & Payroll Taxes	0	13,549	8,329	0	0	0	0	0	0	0	0	21,878	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,600	0	0	0	0	0	0	0	0	0	2,600	24
25	Other Admin. Staff Transportation	0	3,836	7,958	0	0	0	0	0	0	0	0	11,794	25
26	Insurance-Prop.Liab.Malpractice	0	799	1,175	0	0	0	0	0	0	0	0	1,974	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(55,348)</b>	<b>(1,542)</b>	<b>18,996</b>	<b>0</b>	<b>(37,894)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(59,638)</b>	<b>5,327</b>	<b>24,255</b>	<b>0</b>	<b>(30,056)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr

# 0046268

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	0	1,217	1,000	0	0	0	0	0	0	0	0	2,217	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(334)	0	0	0	0	0	0	0	0	0	0	(334)	32
33	Real Estate Taxes	0	10	386	0	0	0	0	0	0	0	0	396	33
34	Rent-Facility & Grounds	0	3,979	2,260	0	0	0	0	0	0	0	0	6,239	34
35	Rent-Equipment & Vehicles	0	0	323	0	0	0	0	0	0	0	0	323	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(334)</b>	<b>5,206</b>	<b>3,969</b>	<b>0</b>	<b>8,841</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(59,972)	10,533	28,224	0	0	0	0	0	0	0	0	(21,215)	45

**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
<a href="#">Stephen P. Miller</a>	<a href="#">100</a>	<a href="#">Helia Healthcare of Belleville</a>	<a href="#">Belleville, IL</a>	<a href="#">Bridgemark Healthcare</a>	<a href="#">St. Louis, MO</a>	<a href="#">Management Co.</a>
		<a href="#">Helia Healthcare of Benton</a>	<a href="#">Benton, IL</a>	<a href="#">Helia Healthcare Services</a>	<a href="#">Benton, IL</a>	<a href="#">Laundry, Maint.</a>
		<a href="#">Helia Healthcare of Champaign</a>	<a href="#">Champaign, IL</a>	<a href="#">Bridgemark Employer Serv.</a>	<a href="#">St. Louis, MO</a>	<a href="#">Human Resources</a>
		<a href="#">Helia Healthcare of Olney</a>	<a href="#">Olney, IL</a>	<a href="#">Bridgemark Medical Serv.</a>	<a href="#">St. Louis, MO</a>	<a href="#">Medical Supplies</a>
		<a href="#">Helia Healthcare of Greenville</a>	<a href="#">Greenville, IL</a>	<a href="#">NW Rehab, LLC</a>	<a href="#">St. Louis, MO</a>	<a href="#">Therapy</a>
		<a href="#">Helia Healthcare of Energy</a>	<a href="#">Energy, IL</a>	<a href="#">Mid-South Health Clinic</a>	<a href="#">Poplar Bluff, MO</a>	<a href="#">Clinic</a>
		<a href="#">Helia Southbelt Healthcare</a>	<a href="#">Belleville, IL</a>			

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	<a href="#">5 Utilities</a>	\$	<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">\$ 26</a>	<a href="#">\$ 26</a>	<a href="#">1</a>
2	V	<a href="#">10 Nursing &amp; Medical Records</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">6,843</a>	<a href="#">6,843</a>	<a href="#">2</a>
3	V	<a href="#">17 Management Fees</a>	<a href="#">109,000</a>	<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">11,721</a>	<a href="#">(97,279)</a>	<a href="#">3</a>
4	V	<a href="#">19 Professional Services</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">2,822</a>	<a href="#">2,822</a>	<a href="#">4</a>
5	V	<a href="#">20 Dues, Subscriptions</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">443</a>	<a href="#">443</a>	<a href="#">5</a>
6	V	<a href="#">21 Clerical &amp; General Office</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">71,688</a>	<a href="#">71,688</a>	<a href="#">6</a>
7	V	<a href="#">22 Employee Benefits &amp; Payroll Taxes</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">13,549</a>	<a href="#">13,549</a>	<a href="#">7</a>
8	V	<a href="#">24 Travel &amp; Seminar</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">2,600</a>	<a href="#">2,600</a>	<a href="#">8</a>
9	V	<a href="#">25 Admin Staff Transportation</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">3,836</a>	<a href="#">3,836</a>	<a href="#">9</a>
10	V	<a href="#">26 Insurance</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">799</a>	<a href="#">799</a>	<a href="#">10</a>
11	V	<a href="#">30 Depreciation</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">1,217</a>	<a href="#">1,217</a>	<a href="#">11</a>
12	V	<a href="#">33 Real Estate Taxes</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">10</a>	<a href="#">10</a>	<a href="#">12</a>
13	V	<a href="#">34 Rent</a>		<a href="#">Bridgemark Healthcare, LLC</a>	<a href="#">100.00%</a>	<a href="#">3,979</a>	<a href="#">3,979</a>	<a href="#">13</a>
14	<b>Total</b>		<b>\$ 109,000</b>			<b>\$ 119,533</b>	<b>\$ * 10,533</b>	<b>14</b>

\* 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	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%	\$ 323	\$	323	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V	5 Utilities		Helia Healthcare Services	100.00%	1,390		1,390	22
23	V	6 Maintenance	3,000	Helia Healthcare Services	100.00%	6,869		3,869	23
24	V	19 Professional Services		Helia Healthcare Services	100.00%	626		626	24
25	V	21 Clerical & Office Supplies		Helia Healthcare Services	100.00%	908		908	25
26	V	22 Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	8,329		8,329	26
27	V	25 Admin Staff Transportation		Helia Healthcare Services	100.00%	7,958		7,958	27
28	V	26 Insurance		Helia Healthcare Services	100.00%	1,175		1,175	28
29	V	30 Depreciation		Helia Healthcare Services	100.00%	1,000		1,000	29
30	V	33 Real Estate Taxes		Helia Healthcare Services	100.00%	386		386	30
31	V	34 Rent		Helia Healthcare Services	100.00%	2,260		2,260	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 3,000			\$ 31,224	\$ *	28,224	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Frankfort Hlthcr & Rehab Ctr

# 0046268

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	288,279	1.95	3.91	Distribution	\$ 11,721	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	\$ 11,721		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 Hlthcr & Rehab Ctr

# 0046268

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	5	Utilities	Resident Days	332,289	13	\$ 671	\$ 12,983	\$ 26	1
2	10	Nursing & Medical Records	Resident Days	332,289	13	175,140	12,983	6,843	2
3	17	Owners Compensation	Resident Days	332,289	13	300,000	12,983	11,721	3
4	19	Professional Fees	Resident Days	332,289	13	72,214	12,983	2,822	4
5	20	Dues, Subscriptions	Resident Days	332,289	13	11,333	12,983	443	5
6	21	Salaries - Other	Resident Days	332,289	13	1,491,031	12,983	58,257	6
7	21	Clerical & Office Supplies	Resident Days	332,289	13	343,761	12,983	13,431	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	332,289	13	346,778	12,983	13,549	8
9	24	Seminars	Resident Days	332,289	13	66,551	12,983	2,600	9
10	25	Admin Staff Travel	Resident Days	332,289	13	98,168	12,983	3,836	10
11	26	Insurance	Resident Days	332,289	13	20,457	12,983	799	11
12	30	Depreciation	Resident Days	332,289	13	31,136	12,983	1,217	12
13	33	Real Estate Taxes	Resident Days	332,289	13	263	12,983	10	13
14	34	Building Rent	Resident Days	332,289	13	94,122	12,983	3,677	14
15	34	Rental - Storage Unit	Resident Days	332,289	13	7,741	12,983	302	15
16	35	Equipment Rental	Resident Days	332,289	13	8,255	12,983	323	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,067,621	\$ 1,666,171		\$ 119,856	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr

# 0046268

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	5	Utilities	Revenue	9,000	3	\$ 4,169	\$ 3,000	\$ 1,390	1
2	6	Maintenance	Revenue	9,000	3	20,606	20,606	6,869	2
3	19	Professional Services	Revenue	9,000	3	1,879	3,000	626	3
4	21	Clerical & Office Supplies	Revenue	9,000	3	2,723	3,000	908	4
5	22	Payroll Taxes & Emp Benefits	Revenue	9,000	3	24,986	3,000	8,329	5
6	25	Other Admin Transportation	Revenue	9,000	3	23,874	3,000	7,958	6
7	26	Insurance	Revenue	9,000	3	3,526	3,000	1,175	7
8	30	Depreciation	Revenue	9,000	3	3,001	3,000	1,000	8
9	33	Real Estate Taxes	Revenue	9,000	3	1,159	3,000	386	9
10	34	Rent	Revenue	9,000	3	6,780	3,000	2,260	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					\$ 92,703	\$ 20,606	\$ 30,901	25

SEE ACCOUNTANTS' COMPILATION REPORT



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$	<b>33,924</b>		<b>1</b>
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.)		\$	<b>35,032</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,108</b>		<b>3</b>
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>34,942</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>36,050</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>32,668</u>	<u>8</u>	<b>FOR BHF USE ONLY</b>	
	2011	<u>32,989</u>	<u>9</u>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$ <b>13</b>
	2012	<u>32,721</u>	<u>10</u>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2013	<u>32,936</u>	<u>11</u>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2014	<u>32,386</u>	<u>12</u>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>36,050 Line 7, Real Estate Tax Portion of Lease Payments</b>					
<b>10 Bridgemark Healthcare Allocation</b>					
<b>386 Helia Healthcare Allocation</b>					
<b>36,446 Total Schedule V, Line 33</b>					

**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' COMPILATION REPORT

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Frankfort Hlthcr & Rehab Ctr COUNTY Franklin  
 FACILITY IDPH LICENSE NUMBER 0046268  
 CONTACT PERSON REGARDING THIS REPORT Michael Parentin  
 TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(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>SEC 20 TWP 07 RNG 03 PT NW SE</u>	\$ <u>32,385.72</u>	\$ <u>32,385.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>32,385.72</u></u>	\$ <u><u>32,385.72</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 11,759 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Related Party Allocation - Helia Healthcare</u>		<u>2006</u>	<u>\$ 1,670</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 1,670</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Frankfort Hlthcr &amp; Rehab Ctr

# 0046268

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	\$ 9,933	\$	20	\$ 497	\$ 497	\$ 4,884
5										
6										
7										
8										
		<b>Improvement Type**</b>								
9		Prior Owner Costs:								
10		Heating & Air Conditioning		2004	4,055					
11		Heating & Air Conditioning		2004	596					
12		Heating & Air Conditioning		2004	416					
13		Heating & Air Conditioning		2004	767					
14		Monitor System		2006	772					
15		Wander Guard		2006	1,400					
16		ADT Fire Alarm System		2007	3,034					
17		Windsor Lighting		2008	1,556					
18		Carpeting		2008	953					
19		Southside Lumber		2008	1,281					
20		Heating & Air Conditioning		2008	665					
21		Heating & Air Conditioning		2008	1,440					
22		Call System & Cable Installation		2009	7,220					
23		Wallcovering		2009	9,958					
24		Carpeting		2009	1,170					
25		Shed		2009	974					
26		Outdoor Facility Signage		2010	2,667					
27		Replace Door/System		2010	3,855					
28		Sprinkler System Improvements		2010	32,932					
29		Dining Room Tile, Paint, Hand Rails, Labor		2011	10,978					
30		Family Room Paint, Flooring, Hand Rails, Drywall, Labor		2011	8,782					
31		Nurse's Station Remodel		2011	6,587					
32		Beauty Shop Paint, Flooring, Cabinet, Sink, Labor		2011	4,391					
33		East Hallway Paint, Flooring, Hand Rails, Drywall, Labor		2011	6,801					
34		West Hallway Paint, Flooring, Hand Rails, Drywall, Labor		2011	6,801					
35		Shower Room Renovations - Tile, Shower Heads, fixtures, paint		2011	3,757					
36		Interlocking Carpet		2011	2,618					

\*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

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	98	10	98		154	42
43	Water Heater	2014	1,412	141	10	141		188	43
44	Room 16 East Hall - toilet, sink, floor remodel	2014	1,465	147	10	147		195	44
45	Room 30 West Hall - drywall, floor, lighting remodel	2014	852	85	10	85		106	45
46	Labor & Material for 5 ton RTU	2014	5,864	586	10	586		684	46
47	Lights, Paint, Flooring for resident rooms A-wing	2015	5,085	254	15	254		254	47
48	Sewage Pipe Replacement	2015	8,400	70	20	70		70	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	Related Party Allocation - Bridgemark HealthcareLLC								56
57	New Office Build-Out	2011	5,307		20	281	281	1,251	57
58	Conference Room Chair Rail & Paint	2012	60		5	12	12	40	58
59									59
60									60
61	Related Party Allocation - Helia Healthcare								61
62	Water & Sewer Pipe Installation	2006	633		20	32	32	298	62
63	Plumbing & Heating Installation	2006	758		20	38	38	357	63
64	A/C Unit - 4 Ton	2007	1,827		10	183	183	1,583	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 194,123	\$ 1,381		\$ 2,424	\$ 1,043	\$ 10,064	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 23,497	\$ 3,367	\$ 4,526	\$ 1,159	7	\$ 8,688	71
72	Current Year Purchases	14,667	995	1,010	15	7	1,010	72
73	Fully Depreciated Assets	11,415					11,415	73
74								74
75	TOTALS	\$ 49,579	\$ 4,362	\$ 5,536	\$ 1,174		\$ 21,113	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Related Party Allocation - Bridgemark		2005	519				4	519	77
78	Related Party Allocation - Helia		2006	2,237				4	2,237	78
79										79
80	TOTALS			\$ 2,756	\$	\$	\$		\$ 2,756	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)	\$ 248,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,743	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,960	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,217	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 33,933	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' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Champaign, Williamson, Franklin, L.L.C.  
 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>85,606</u>			3
4	Additions							4
5	Related Party Allocations				<u>6,239</u>			5
6	Storage Rental				<u>500</u>			6
7	TOTAL		<u>57</u>		\$ <u>92,345</u>			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>/2016</u>	\$ <u>84,000</u>
13.	<u>/2017</u>	\$ <u>84,000</u>
14.	<u>/2018</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: \$ 3,514 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' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/15 Ending: 12/31/15  
 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**

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

- (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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				157		157	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				83,572		83,572	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					14,462		14,462	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3				172,812			172,812	13
14	<b>TOTAL</b>			\$		\$ 172,812	\$ 98,191		\$ 271,003	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 Hlthcr & Rehab Ctr**

# **0046268**

Report Period Beginning: **01/01/15**

Ending:

**12/31/15**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/15** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,677	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (192) )	559,081		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,768		7
8	Accounts Receivable (owners or related parties)	1,198,225		8
9	Other(specify): <u>Deposits</u>	21,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,784,751	\$	10
<b>B. Long-Term Assets</b>				
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	33,989		15
16	Equipment, at Historical Cost	21,347		16
17	Accumulated Depreciation (book methods)	(7,159)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	34,942		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 83,119	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,867,870	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 299,852	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,197		30
31	Accrued Taxes Payable (excluding real estate taxes)	267		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,942		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Assessment Fees</u>	10,832		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 377,090	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Note Payable - Owner</u>	81,364		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 81,364	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 458,454	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,409,416	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,867,870	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,579,497	1
2	Restatements (describe):		2
3	Prior Year Adjustment for Workers Comp Audit	(27,951)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,551,546	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(142,130)	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)	\$ (142,130)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,409,416	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,130,269	1
2	Discounts and Allowances for all Levels	(24,151)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,106,118</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	45,117	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 45,117</b>	8
<b>C. Other Operating Revenue</b>			
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	10	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 10</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	334	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 334</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Flu Shots</u>	1,322	28
28a	<u>Miscellaneous</u>	983	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,305</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,153,884</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	478,643	31
32	Health Care	714,620	32
33	General Administration	568,569	33
<b>B. Capital Expense</b>			
34	Ownership	166,198	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	270,845	35
36	Provider Participation Fee	97,139	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,296,014</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(142,130)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (142,130)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,036,174	44
45	Private Pay - Net Inpatient Revenue	250,920	45
46	Medicare - Net Inpatient Revenue	709,073	46
47	Other-(specify) <u>Insurance</u>	58,993	47
48	Other-(specify) <u>Hospice</u>	50,958	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,106,118</b>	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' COMPILATION REPORT**

Facility Name & ID Number **Frankfort Hlth & Rehab Ctr**

# **0046268**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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	2,047	2,173	\$ 58,774	\$ 27.05	1
2	Assistant Director of Nursing	870	927	22,618	24.40	2
3	Registered Nurses	5,688	6,262	140,314	22.41	3
4	Licensed Practical Nurses	4,452	4,758	93,561	19.66	4
5	CNAs & Orderlies	22,103	23,666	243,930	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,837	2,128	28,824	13.55	9
10	Activity Assistants					10
11	Social Service Workers	1,786	2,046	37,756	18.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,406	6,863	77,293	11.26	15
16	Dishwashers					16
17	Maintenance Workers	1,856	2,135	51,787	24.26	17
18	Housekeepers	4,019	4,634	56,294	12.15	18
19	Laundry	1,596	1,701	17,624	10.36	19
20	Administrator	1,911	2,194	75,260	34.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	973	1,115	20,572	18.45	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)	55,544	60,602	\$ 924,607 *	\$ 15.26	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	\$ 4,816	1,3	35
36	Medical Director	6,000	9,3	36
37	Medical Records Consultant	150	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,332	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	3,651	11,3	44
45	Social Service Consultant	1,871	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,820		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

Facility Name & ID Number **Frankfort Hlthcr & Rehab Ctr**

# **0046268**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Susan M Williams	Administrator	0	\$ 31,360	Workers' Compensation Insurance	\$ 38,358	IDPH License Fee	\$ 1,990	
Misty Hargett	Administrator	0	43,900	Unemployment Compensation Insurance	31,501	Advertising: Employee Recruitment	5,538	
				FICA Taxes	67,717	Health Care Worker Background Check	2,247	
				Employee Health Insurance	18,729	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,931	
				401(k) Match	1,718	Late Fees	1,487	
				Employee Benefits	2,880	Miscellaneous Licenses & Fees	809	
				Other Employee Insurance	1,392	Advertising	40,593	
						Related Party Allocation - Bridgemark	443	
						Less: Public Relations Expense ( _____)		
						Non-allowable advertising (40,593)		
						Yellow page advertising ( _____)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,260	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
Bridgemark Healthcare LLC - Management Fees			\$ 109,000	Related Party Allocation - Bridgemark			13,549	
				Related Party Allocation - Helia			8,329	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 109,000	TOTAL			\$ 184,173	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C.J. Schlosser & Company, LLC	Accounting Services		\$ 4,297	Section N/A		\$	Out-of-State Travel	\$
Paycom Payroll, LLC	Payroll Processing		5,677					
Personnel Planners, Inc.	Unemployment Consulting		1,561					
HK Payroll Services	WOTC		962				In-State Travel	544
Federal Fire & Security	Fire Alarm Monitoring		360					
Ashman & Stein	Legal - Notice of Defaults		118					
Kramer & Frank	Collection Fees - Eliminated		25				Seminar Expense	806
							Related Party Allocation - Bridgemark	2,600
							Entertainment Expense ( _____)	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 13,000	TOTAL		\$	TOTAL	\$ 3,950

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Frankfort Hlthcr &amp; Rehab Ctr

# 0046268

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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 \$2,145
- (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? 5-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,413 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. \$ 97,139  
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' COMPILATION 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. \$ 10
- (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  
12/31/2015

<u>Description</u>		
16A	Nursing Equipment	2,281
16B	Copier Lease	486
16C	Dietary Equipment	424
16D	Related Party Allocation - Bridgemark Healthcare	323
		<u>3,514</u>