FOR BHF USE

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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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0046268

Facility Name: Frankfort HC & Rehab Ctr

Address: 2500 E St Louis St (Number) | West Frankfort (City) | 62896 (Zip Code)

County: Franklin

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618)465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002
(Telephone) (618)465-7717 Fax # (618)465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,346	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,528	1,729	1,688	15,945	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,528	1,729	1,688	15,945	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.43%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,566

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	86,775	11,574	4,539	102,888		102,888		102,888			1
2	Food Purchase		78,732		78,732		78,732	(42)	78,690			2
3	Housekeeping	69,651	9,185		78,836		78,836		78,836			3
4	Laundry	13,863	11,960	52,128	77,951		77,951		77,951			4
5	Heat and Other Utilities			35,572	35,572		35,572	(6,816)	28,756			5
6	Maintenance	41,765	6,110	37,114	84,989		84,989	16,523	101,512			6
7	Other (specify):*											7
8	**TOTAL General Services**	212,054	117,561	129,353	458,968		458,968	9,665	468,633			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	555,168	49,189	1,599	605,956		605,956	4,883	610,839			10
10a	Therapy		195	100	295		295		295			10a
11	Activities	24,495	27,200	3,345	55,040		55,040		55,040			11
12	Social Services	24,681		1,951	26,632		26,632		26,632			12
13	CNA Training											13
14	Program Transportation			182	182		182		182			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	604,344	76,584	13,177	694,105		694,105	4,883	698,988			16
	C. General Administration											
17	Administrative	69,170		110,800	179,970		179,970	(91,438)	88,532			17
18	Directors Fees											18
19	Professional Services			13,738	13,738		13,738	7,599	21,337			19
20	Dues, Fees, Subscriptions & Promotions			40,354	40,354		40,354	(28,776)	11,578			20
21	Clerical & General Office Expenses		7,739	37,050	44,789		44,789	103,347	148,136			21
22	Employee Benefits & Payroll Taxes			156,897	156,897		156,897	26,279	183,176			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,377	2,377		2,377	2,008	4,385			24
25	Other Admin. Staff Transportation			4,667	4,667		4,667	8,667	13,334			25
26	Insurance-Prop.Liab.Malpractice			33,885	33,885		33,885	1,046	34,931			26
27	Other (specify):*											27
28	**TOTAL General Administration**	69,170	7,739	399,768	476,677		476,677	28,732	505,409			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	885,568	201,884	542,298	1,629,750		1,629,750	43,280	1,673,030			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 HC & Rehab Ctr #0046268 Report Period Beginning: 01/01/12 Ending: 12/31/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,906	16,906		16,906	5,364	22,270			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,011	32,011		32,011	10,538	42,549			32
33	Real Estate Taxes			24,300	24,300		24,300	3,065	27,365			33
34	Rent-Facility & Grounds			124,500	124,500		124,500	7,842	132,342			34
35	Rent-Equipment & Vehicles			5,597	5,597		5,597	173	5,770			35
36	Other (specify):*											36
37	**TOTAL Ownership**			203,314	203,314		203,314	26,982	230,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,116	164,587	228,703		228,703		228,703			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,490	175,490		175,490		175,490			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,116	340,077	404,193		404,193		404,193			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	885,568	266,000	1,085,689	2,237,257		2,237,257	70,262	2,307,519			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 HC & Rehab Ctr # 0046268 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,835)	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	926	30		9
10	Interest and Other Investment Income	(134)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	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	(57)	21		18
19	Entertainment	(3,383)	21		19
20	Contributions	(356)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(20)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,207)	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	(12,036)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (41,294)		$	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 Amount	2 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)	111,556	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 111,556		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 70,262		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Frankfort HC & Rehab Ctr

ID# **0046268**

Report Period Beginning: **01/01/12**

Ending: **12/31/12**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (8,802)	20	1
2	Eliminate Lobbying & PAC Dues	(843)	20	2
3	Offset Medical Records Income	(401)	10	3
4	Eliminate 2013 IDPH Fees	(1,990)	20	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**	(12,036)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(42)	0	0	0	0	0	0	0	0	0	0	(42)	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	(8,835)	1,812	207	0	0	0	0	0	0	0	0	(6,816)	5
6	Maintenance	0	16,523	0	0	0	0	0	0	0	0	0	16,523	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,877)	18,335	207	0	0	0	0	0	0	0	0	9,665	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(401)	0	5,284	0	0	0	0	0	0	0	0	4,883	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(401)	0	5,284	0	0	0	0	0	0	0	0	4,883	16
	C. General Administration													
17	Administrative	0	0	(91,438)	0	0	0	0	0	0	0	0	(91,438)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20)	784	6,835	0	0	0	0	0	0	0	0	7,599	19
20	Fees, Subscriptions & Promotions	(28,992)	0	216	0	0	0	0	0	0	0	0	(28,776)	20
21	Clerical & General Office Expenses	(3,796)	1,221	105,922	0	0	0	0	0	0	0	0	103,347	21
22	Employee Benefits & Payroll Taxes	0	7,932	18,347	0	0	0	0	0	0	0	0	26,279	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,008	0	0	0	0	0	0	0	0	2,008	24
25	Other Admin. Staff Transportation	0	5,236	3,431	0	0	0	0	0	0	0	0	8,667	25
26	Insurance-Prop.Liab.Malpractice	0	287	759	0	0	0	0	0	0	0	0	1,046	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(32,808)	15,460	46,080	0	0	0	0	0	0	0	0	28,732	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,086)	33,795	51,571	0	0	0	0	0	0	0	0	43,280	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense D. Ownership	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)	
30	Depreciation	926	1,733	2,705	0	0	0	0	0	0	0	0	5,364	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(134)	8,792	1,880	0	0	0	0	0	0	0	0	10,538	32
33	Real Estate Taxes	0	3,000	65	0	0	0	0	0	0	0	0	3,065	33
34	Rent-Facility & Grounds	0	1,650	6,192	0	0	0	0	0	0	0	0	7,842	34
35	Rent-Equipment & Vehicles	0	0	173	0	0	0	0	0	0	0	0	173	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	792	15,175	11,015	0	0	0	0	0	0	0	0	26,982	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,294)	48,970	62,586	0	0	0	0	0	0	0	0	70,262	45

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

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 Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical Supply	St. Louis, MO	Medical Supplies
		Helia Healthcare of Energy	Energy, IL			
		Helia Healthcare of Olney	Olney, IL			
		Helia Healthcare of Greenville	Greenville, 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. [X] 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	5	Utilities	$	Helia Healthcare Services	100.00%	$ 1,812	$ 1,812	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	19,523	16,523	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	784	784	3
4	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,221	1,221	4
5	V	22	Payroll Taxes & Emp. Benefits		Helia Healthcare Services	100.00%	7,932	7,932	5
6	V	25	Other Admin Transportation		Helia Healthcare Services	100.00%	5,236	5,236	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	287	287	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	1,733	1,733	8
9	V	32	Interest		Helia Healthcare Services	100.00%	8,792	8,792	9
10	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	3,000	3,000	10
11	V	34	Rent		Helia Healthcare Services	100.00%	1,650	1,650	11
12	V								12
13	V								13
14	Total			$ 3,000			$ 51,970	$ * 48,970	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. [X] 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)	
15	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 207	$ 207	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	5,284	5,284	16
17	V	17	Management Fees	110,800	Bridgemark Healthcare, LLC	100.00%	19,362	(91,438)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	6,835	6,835	18
19	V	20	Dues, Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	216	216	19
20	V	21	Clerical & General Office Exp		Bridgemark Healthcare, LLC	100.00%	105,922	105,922	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	18,347	18,347	21
22	V	24	Travel & Seminars		Bridgemark Healthcare, LLC	100.00%	2,008	2,008	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,431	3,431	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	759	759	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,705	2,705	25
26	V	32	Interest		Bridgemark Healthcare, LLC	100.00%	1,880	1,880	26
27	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	65	65	27
28	V	34	Rent-Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	6,192	6,192	28
29	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	173	173	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 110,800			$ 173,386	$ * 62,586	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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								1
2			Helia Southbelt Healthcare	Belleville, IL				2
3			Helia Healthcare of Rolla	Rolla, MO				3
4			Hillside Rehab & Care Center	Yorkville, IL				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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	317,263	2.88	5.75	Distribution	$ 19,362	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	$ 19,362		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 HC & Rehab Ctr # 0046268 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	277,215	11	$ 3,605	$	15,945	$ 207	1
2	10	Nursing & Medical Records	Resident Days	277,215	11	91,867	91,867	15,945	5,284	2
3	17	Owners Compensation	Resident Days	277,215	11	336,625		15,945	19,362	3
4	19	Professional Fees	Resident Days	277,215	11	118,827		15,945	6,835	4
5	20	Dues, Subscriptions	Resident Days	277,215	11	3,754		15,945	216	5
6	21	Salaries-Other	Resident Days	277,215	11	1,345,667	1,345,667	15,945	77,401	6
7	21	Clerical & Office Supplies	Resident Days	277,215	11	495,853		15,945	28,521	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	277,215	11	318,977		15,945	18,347	8
9	24	Seminars	Resident Days	277,215	11	34,902		15,945	2,008	9
10	25	Admin Staff Travel	Resident Days	277,215	11	59,659		15,945	3,431	10
11	26	Insurance	Resident Days	277,215	11	13,196		15,945	759	11
12	30	Depreciation	Resident Days	277,215	11	47,028		15,945	2,705	12
13	32	Interest	Resident Days	277,215	11	32,681		15,945	1,880	13
14	33	Real Estate Taxes	Resident Days	277,215	11	1,133		15,945	65	14
15	34	Building Rent	Resident Days	277,215	11	103,521		15,945	5,954	15
16	34	Rental-Storage Unit	Resident Days	277,215	11	4,139		15,945	238	16
17	35	Equipment Rental	Resident Days	277,215	11	3,007		15,945	173	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,014,441	$ 1,437,534		$ 173,386	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Revenue	12,000	4	$ 7,249	$	3,000	$ 1,812	1
2	6	Mainenance	Revenue	12,000	4	78,091	75,311	3,000	19,523	2
3	19	Professional Services	Revenue	12,000	4	3,135		3,000	784	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	4,882		3,000	1,221	4
5	22	Payroll Taxes & Emp. Ben.	Revenue	12,000	4	31,729		3,000	7,932	5
6	25	Other Admin Transportation	Revenue	12,000	4	20,942		3,000	5,236	6
7	26	Insurance	Revenue	12,000	4	1,148		3,000	287	7
8	30	Depreciation	Revenue	12,000	4	6,932		3,000	1,733	8
9	32	Interest	Revenue	12,000	4	35,169		3,000	8,792	9
10	33	Real Estate Taxes	Revenue	12,000	4	12,000		3,000	3,000	10
11	34	Rent	Revenue	12,000	4	6,600		3,000	1,650	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					$ 207,877	$ 75,311		$ 51,970	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	32,011	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 32,011	9
	B. Non-Facility Related*											
10	Interest Income		X								(134)	10
11	Related Party Allocation - Bridgemark Healthcare										1,880	11
12	Related Party Allocation - Helia Healthcare										8,792	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 10,538	14
15	TOTALS (line 9+line14)						$	$			$ 42,549	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 24,300	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,300	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 24,300	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	31,022	8
	2008	31,878	9
	2009	32,746	10
	2010	32,668	11
	2011	32,989	12

24,300 Line 7, Real Estate Tax portion of Lease Payment
65 Bridgemark Healthcare Allocation
3,000 Helia Healthcare Allocation
27,365 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Frankfort HC & 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-20-402-009	SEC20 TWP 07 RNG 03 PT NW SE	$ 32,988.54	$ 32,988.54
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,988.54	$ 32,988.54

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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

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. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Related Party Allocation - Helia		2006	$ 1,250	1
2					2
3	TOTALS			$ 1,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related Party Allocation - Helia		2006	2006	$ 7,450	$	20	$ 373	$ 373	$ 2,546	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heating & Air Conditioning			2004	4,055		5			4,055	9
10	Heating & Air Conditioning			2004	596		5			596	10
11	Heating & Air Conditioning			2004	416		5			416	11
12	Heating & Air Conditioning			2004	767		3			767	12
13	Monitor System			2006	772		5			772	13
14	Wander Guard			2006	1,400		5			1,400	14
15	ADT Fire Alarm System			2007	3,034	433	7	433		2,367	15
16	Windsor Lighting			2008	1,556	156	10	156		687	16
17	Carpeting			2008	953	191	5	191		810	17
18	Southside Lumber			2008	1,281	128	10	128		523	18
19	Heating & Air Conditioning			2008	665	133	5	133		610	19
20	Heating & Air Conditioning			2008	1,440	288	5	288		1,248	20
21	Call System & Cable Installation			2009	7,220	722	10	722		2,580	21
22	Wallcovering			2009	9,958	664	15	664		2,213	22
23	Carpeting			2009	1,170	234	5	234		761	23
24	Shed			2009	974	97	10	97		333	24
25	Outdoor Facility Signage			2010	2,667	267	10	267		578	25
26	Replace Door/System			2010	3,855	257	15	257		643	26
27	Sprinkler System Improvements			2010	32,932	439	25	1,317	878	2,744	27
28	Dining Room Tile, Paint, Hand Rails, Labor			2011	10,978	732	15	732		1,464	28
29	Family Room Paint, Flooring, Hand Rails, Drywall, Labor			2011	8,782	586	15	586		1,171	29
30	Nurse's Station Remodel			2011	6,587	439	15	439		878	30
31	Beauty Shop Paint, Flooring, Cabinets, Sink, Labor			2011	4,391	293	15	293		586	31
32	East Hallway Paint, Flooring, Hand Rails, Drywall, Labor			2011	6,801	642	15	453	(189)	831	32
33	West Hallway Paint, Flooring, Hand Rails, Drywall, Labor			2011	6,801	642	15	453	(189)	831	33
34	Shower Room Renovations - Tile, Shower Heads, Fixtures, Paint			2011	3,757	355	15	250	(105)	459	34
35	Interlocking Carpet			2011	2,618	536	5	524	(12)	567	35
36	3 Fire Doors for POC			2012	4,839	296	15	296		296	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace Roof	2012	$ 13,205	$ 1,100	10	$ 1,100	$	$ 1,100	37
38	Arcoaire 5 ton package unit	2012	5,580	326	10	326		326	38
39									39
40	Allocation from Helia Healthcare Services								40
41	Water & Swer Pipe Installation	2006	475		20	24	24	153	41
42	Plumbing & Heating Installation	2006	569		20	28	28	183	42
43	4-Ton A/C Unit	2007	1,370		10	137	137	776	43
44									44
45									45
46	Related Party Allocation-Bridgemark Healthcare								46
47	New Office Build-Out	2011	7,812		20	414	414	601	47
48	Conference Rm Chair Rail & Paint	2012	88		5	6	6	6	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 167,814	$ 9,956		$ 11,321	$ 1,365	$ 36,877	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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	$ 58,586	$ 4,313	$ 7,424	$ 3,111		$ 32,181	71
72	Current Year Purchases	8,484	538	728	190		728	72
73	Fully Depreciated Assets	33,507					33,507	73
74								74
75	TOTALS	$ 100,577	$ 4,851	$ 8,152	$ 3,301		$ 66,416	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	Facility	Bus	2008	$ 3,500	$ 700	$ 700	$	5	$ 3,033	76
77	Facility	2001 Doge Ram	2011	6,500	1,399	1,625	226	4	2,302	77
78	Related Party Allocation-Bridgemark			764		191	191	5	685	78
79	Related Party Allocation-Helia			1,678		281	281	5	1,373	79
80	TOTALS			$ 12,442	$ 2,099	$ 2,797	$ 698		$ 7,393	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)	$ 282,083	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,906	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,270	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,364	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 110,686	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	Schedule 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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Marion Properties

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		57		$ 124,500			3
4	Additions							4
5	Related Party Allocation-Bridgemark				6,192			5
6	Related Party Allocation-Helia				1,650			6
7	TOTAL		57		$ 132,342 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 5,770 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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 HC & Rehab Ctr # 0046268 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	2	3	4	5	6	7	8	
	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				195		195	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				52,683		52,683	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enteral	39,2					11,433		11,433	12
13	Physical, Occupational & Speech Ther Other (specify): X-Ray & Labs	39,3				164,587			164,587	13
14	TOTAL			$		$ 164,587	$ 64,311		$ 228,898	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

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 753	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 71,028)	608,653		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,720		7
8	Accounts Receivable (owners or related parties)	1,080,063		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,691,189	$	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	143,288		15
16	Equipment, at Historical Cost	97,115		16
17	Accumulated Depreciation (book methods)	(90,798)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 149,605	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,840,794	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 259,247	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,312		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,931		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessment	60,859		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 389,349	$	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	Note Payable - Owner	81,365		43
44	Note Payable - Lessor	59,905		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 141,270	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 530,619	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,310,175	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,840,794	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,233,507	1
2	Restatements (describe):		2
3	**Prior Year Depreciation Adjustment**	(926)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,232,581	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	77,594	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)**	$ 77,594	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)**	$ 1,310,175	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,288,255	1
2	Discounts and Allowances for all Levels	(32,900)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,255,355	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	57,919	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 57,919	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	134	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 134	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	1,443	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,443	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,314,851	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	458,968	31
32	Health Care	694,105	32
33	General Administration	476,677	33
	B. Capital Expense		
34	Ownership	203,314	34
	C. Ancillary Expense		
35	Special Cost Centers	404,193	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,237,257	40
41	**Income before Income Taxes (line 30 minus line 40)****	77,594	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 77,594	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,463,654	44
45	Private Pay - Net Inpatient Revenue	157,859	45
46	Medicare - Net Inpatient Revenue	604,637	46
47	Other-(specify) Insurance	22,081	47
48	Other-(specify) Hospice	7,124	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,255,355	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,007	2,066	$ 52,022	$ 25.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,875	3,105	62,372	20.09	3
4	Licensed Practical Nurses	7,916	9,012	173,782	19.28	4
5	CNAs & Orderlies	23,770	26,321	266,992	10.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,879	2,079	24,495	11.78	9
10	Activity Assistants					10
11	Social Service Workers	1,794	2,003	24,681	12.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,708	7,486	86,775	11.59	15
16	Dishwashers					16
17	Maintenance Workers	1,934	2,104	41,765	19.85	17
18	Housekeepers	5,453	5,939	69,651	11.73	18
19	Laundry	1,301	1,430	13,863	9.69	19
20	Administrator	1,936	2,211	69,170	31.28	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)	57,573	63,756	$ 885,568 *	$ 13.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 4,539	1,3	35
36	Medical Director		6,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,599	10,3	39
40	Physical Therapy Consultant		100	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,345	11,3	44
45	Social Service Consultant		1,951	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,534		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 HC & Rehab Ctr # 0046268 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Misty Hargett	Administrator	0	$ 57,411
Steven Johnson	Administrator	0	11,759
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,170

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 110,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 110,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 4,025
Ceridian	Payroll Processing	7,714
Kramer & Frank	Collections - Eliminated	20
Personnel Planners	Unemployment Consultants	1,395
Secretary of State	Annual LLC	250
Marie Celestin	Business Filings	334
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 13,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,031
Unemployment Compensation Insurance	51,152
FICA Taxes	67,383
Employee Health Insurance	8,095
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	1,325
Employee Benefits	3,668
Uniforms	670
Other Employee Insurance	2,573
Related Party Allocation-Bridgemark	18,347
Related Party Allocation-Helia	7,932
TOTAL (agree to Schedule V, line 22, col.8)	$ 183,176

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,693
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	2,100
Dues & Subscriptions	1,362
Late Fees	1,034
Miscellaneous Licenses & Fees	1,183
Related Party Allocation-Bridgemark	216
Advertising	17,207
Less: Public Relations Expense	( )
Non-allowable advertising	(17,207)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,578

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	678
Seminar Expense	1,699
Related Pary Allocation-Bridgemark	2,008
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,385

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Amount of Expense Amortized Per Year								
					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	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 $1,152**

(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. $ **9,754** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **175,490**
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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Frankfort Healthcare & Rehab Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2012

	Description	
16A	Nursing Equipment	$ 192
16B	Dietary Equipment	1,325
16C	Copier Lease	4,080
16D	Related Party Allocation - Bridgemark	173
		$ 5,770

Frankfort Healthcare & Rehab Center
Attachment to Schedule XVII
Other Income
12/31/2012

	Description		
16A	Medical Record Copies	$	401
16B	Vaccines		947
16C	Miscellaneous Income		95
		$	1,443