FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0046268

Facility Name: Frankfort Hlthcr & 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: 10/01/2003

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 01/01/14 to 12/31/14 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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,315	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,633	1,897	2,507	14,037	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,633	1,897	2,507	14,037	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.47%

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 04/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2003 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 1,922

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: 12/31/14 Fiscal Year: 12/31/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	75,790	7,221	4,768	87,779		87,779		87,779			1
2	Food Purchase		90,870		90,870		90,870	(61)	90,809			2
3	Housekeeping	66,087	9,961	4,622	80,670		80,670		80,670			3
4	Laundry	14,612	11,702	43,019	69,333		69,333		69,333			4
5	Heat and Other Utilities			35,338	35,338		35,338	(2,723)	32,615			5
6	Maintenance	48,930	7,198	43,466	99,594		99,594	15,232	114,826			6
7	Other (specify):*											7
8	**TOTAL General Services**	205,419	126,952	131,213	463,584		463,584	12,448	476,032			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	541,816	46,690	18,941	607,447		607,447	7,820	615,267			10
10a	Therapy		104		104		104		104			10a
11	Activities	27,416	15,397	3,974	46,787		46,787		46,787			11
12	Social Services	37,177		1,876	39,053		39,053		39,053			12
13	CNA Training											13
14	Program Transportation			1,184	1,184		1,184		1,184			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	606,409	62,191	31,975	700,575		700,575	7,820	708,395			16
	C. General Administration											
17	Administrative	71,363		116,700	188,063		188,063	(83,140)	104,923			17
18	Directors Fees											18
19	Professional Services			14,420	14,420		14,420	4,214	18,634			19
20	Dues, Fees, Subscriptions & Promotions			69,847	69,847		69,847	(51,569)	18,278			20
21	Clerical & General Office Expenses	15,499	16,977	67,470	99,946		99,946	84,067	184,013			21
22	Employee Benefits & Payroll Taxes			154,767	154,767		154,767	21,163	175,930			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,693	2,693		2,693	3,129	5,822			24
25	Other Admin. Staff Transportation			5,809	5,809		5,809	8,814	14,623			25
26	Insurance-Prop.Liab.Malpractice			21,782	21,782		21,782	2,405	24,187			26
27	Other (specify):*											27
28	**TOTAL General Administration**	86,862	16,977	453,488	557,327		557,327	(10,917)	546,410			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	898,690	206,120	616,676	1,721,486		1,721,486	9,351	1,730,837			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: 01/01/14 Ending: 12/31/14

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			1,416	1,416		1,416	2,789	4,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,838	24,838		24,838	(1,318)	23,520			32
33	Real Estate Taxes			32,816	32,816		32,816	15	32,831			33
34	Rent-Facility & Grounds			84,150	84,150		84,150	7,585	91,735			34
35	Rent-Equipment & Vehicles			5,767	5,767		5,767	125	5,892			35
36	Other (specify):*											36
37	TOTAL Ownership			148,987	148,987		148,987	9,196	158,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,947	199,162	279,109		279,109		279,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,864	110,864		110,864		110,864			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		79,947	310,026	389,973		389,973		389,973			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	898,690	286,067	1,075,689	2,260,446		2,260,446	18,547	2,278,993			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: 01/01/14 Ending: 12/31/14

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	(3,848)	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	(1,318)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(61)	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	(3,300)	21		18
19	Entertainment	(6,719)	21		19
20	Contributions	(1,456)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(36,942)	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	(14,707)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,501)		$	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)	87,048	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 87,048		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 18,547		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 Hlthcr & Rehab Ctr

ID# **0046268**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (14,002)	20	1
2	Eliminate Lobbying & PAC Dues	(705)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,707)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(61)	0	0	0	0	0	0	0	0	0	0	(61)	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	(3,848)	997	128	0	0	0	0	0	0	0	0	(2,723)	5
6	Maintenance	0	15,232	0	0	0	0	0	0	0	0	0	15,232	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,909)	16,229	128	0	0	0	0	0	0	0	0	12,448	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	7,820	0	0	0	0	0	0	0	0	7,820	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	7,820	0	0	0	0	0	0	0	0	7,820	16
	C. General Administration													
17	Administrative	0	0	(83,140)	0	0	0	0	0	0	0	0	(83,140)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,399	2,815	0	0	0	0	0	0	0	0	4,214	19
20	Fees, Subscriptions & Promotions	(51,799)	0	230	0	0	0	0	0	0	0	0	(51,569)	20
21	Clerical & General Office Expenses	(11,475)	587	94,955	0	0	0	0	0	0	0	0	84,067	21
22	Employee Benefits & Payroll Taxes	0	6,787	14,376	0	0	0	0	0	0	0	0	21,163	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,129	0	0	0	0	0	0	0	0	3,129	24
25	Other Admin. Staff Transportation	0	5,422	3,392	0	0	0	0	0	0	0	0	8,814	25
26	Insurance-Prop.Liab.Malpractice	0	915	1,490	0	0	0	0	0	0	0	0	2,405	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(63,274)	15,110	37,247	0	0	0	0	0	0	0	0	(10,917)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(67,183)	31,339	45,195	0	0	0	0	0	0	0	0	9,351	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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)	
	D. Ownership													
30	Depreciation	0	668	2,121	0	0	0	0	0	0	0	0	2,789	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,318)	0	0	0	0	0	0	0	0	0	0	(1,318)	32
33	Real Estate Taxes	0	0	15	0	0	0	0	0	0	0	0	15	33
34	Rent-Facility & Grounds	0	1,695	5,890	0	0	0	0	0	0	0	0	7,585	34
35	Rent-Equipment & Vehicles	0	0	125	0	0	0	0	0	0	0	0	125	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,318)	2,363	8,151	0	0	0	0	0	0	0	0	9,196	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)**	(68,501)	33,702	53,346	0	0	0	0	0	0	0	0	18,547	45

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 997	$ 997	1
2	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	18,232	15,232	2
3	V	19	Professional Services		Helia Healthcare Services	100.00%	1,399	1,399	3
4	V	21	Clerical & General Office		Helia Healthcare Services	100.00%	587	587	4
5	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	6,787	6,787	5
6	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	5,422	5,422	6
7	V	26	Insurance		Helia Healthcare Services	100.00%	915	915	7
8	V	30	Depreciation		Helia Healthcare Services	100.00%	668	668	8
9	V	34	Rent		Helia Healthcare Services	100.00%	1,695	1,695	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,000			$ 36,702	$ * 33,702	14

*** 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: 01/01/14 Ending: 12/31/14

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%	$ 128	$ 128	15
16	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	7,820	7,820	16
17	V	17	Administrative	116,700	Bridgemark Healthcare, LLC	100.00%	33,560	(83,140)	17
18	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	2,815	2,815	18
19	V	20	Dues, Subscriptions & Promotions		Bridgemark Healthcare, LLC	100.00%	230	230	19
20	V	21	Clerical & General Office Expenses		Bridgemark Healthcare, LLC	100.00%	94,955	94,955	20
21	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	14,376	14,376	21
22	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,129	3,129	22
23	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,392	3,392	23
24	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,490	1,490	24
25	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,121	2,121	25
26	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	15	15	26
27	V	34	Rent - Facility & Grounds		Bridgemark Healthcare, LLC	100.00%	5,890	5,890	27
28	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	125	125	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,700			$ 170,046	$ * 53,346	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: 01/01/14 Ending: 12/31/14

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			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	560,137	2.83	5.65	Distribution	$ 33,560	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	$ 33,560		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: 01/01/14 Ending: 12/31/14

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	248,320	10	$ 2,267	$	14,037	$ 128	1
2	10	Nursing & Medical Records	Resident Days	248,320	10	138,347	138,347	14,037	7,820	2
3	17	Owners Compensation	Resident Days	248,320	10	593,697		14,037	33,560	3
4	19	Professional Fees	Resident Days	248,320	10	49,802		14,037	2,815	4
5	20	Dues, Subscriptions	Resident Days	248,320	10	4,062		14,037	230	5
6	21	Salaries - Other	Resident Days	248,320	10	1,347,083	1,347,083	14,037	76,148	6
7	21	Clerical & Office Supplies	Resident Days	248,320	10	332,712		14,037	18,807	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	248,320	10	254,317		14,037	14,376	8
9	24	Seminars	Resident Days	248,320	10	55,362		14,037	3,129	9
10	25	Admin Staff Travel	Resident Days	248,320	10	60,000		14,037	3,392	10
11	26	Insurance	Resident Days	248,320	10	26,357		14,037	1,490	11
12	30	Depreciation	Resident Days	248,320	10	37,526		14,037	2,121	12
13	33	Real Estate Taxes	Resident Days	248,320	10	261		14,037	15	13
14	34	Building Rent	Resident Days	248,320	10	94,122		14,037	5,321	14
15	34	Rental - Storage Unit	Resident Days	248,320	10	10,067		14,037	569	15
16	35	Equipment Rental	Resident Days	248,320	10	2,216		14,037	125	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,008,198	$ 1,485,430		$ 170,046	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 3,989	$	3,000	$ 997	1
2	6	Maintenance	Revenue	12,000	4	72,927	72,927	3,000	18,232	2
3	19	Professional Services	Revenue	12,000	4	5,597		3,000	1,399	3
4	21	Clerical & Office Supplies	Revenue	12,000	4	2,348		3,000	587	4
5	22	Payroll Taxes & Emp. Bene.	Revenue	12,000	4	27,148		3,000	6,787	5
6	25	Other Admin Transportation	Revenue	12,000	4	21,686		3,000	5,422	6
7	26	Insurance	Revenue	12,000	4	3,659		3,000	915	7
8	30	Depreciation	Revenue	12,000	4	2,670		3,000	668	8
9	34	Rent	Revenue	12,000	4	6,780		3,000	1,695	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	TOTALS					$ 146,804	$ 72,927		$ 36,702	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			10/22/09				Variable	24,838	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 24,838	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,318)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,318)	14
15	TOTALS (line 9+line14)						$	$			$ 23,520	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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 34,044	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.)		$ 32,936	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,108)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 33,924	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.		$ 32,816	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	32,746	8
	2010	32,668	9
	2011	32,989	10
	2012	32,721	11
	2013	32,936	12

32,816	Line 7, Real Estate Tax Portion of Lease Payments		
15	Bridgemark Healthcare Allocation		
32,831	Total Schedule V, Line 33		

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-20-402-009	SEC 20 TWP 07 RNG 03 PT NW SE	$ 32,935.82	$ 32,935.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,935.82	$ 32,935.82

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Healthcare		2006	$ 1,253	1
2					2
3	TOTALS			$ 1,253	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Healthcare		2006	2006	$ 7,450	$	20	$ 372	$ 372	$ 3,291	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	Heating & Air Conditioning			2004	4,055						10
11	Heating & Air Conditioning			2004	596						11
12	Heating & Air Conditioning			2004	416						12
13	Heating & Air Conditioning			2004	767						13
14	Monitor System			2006	772						14
15	Wander Guard			2006	1,400						15
16	ADT Fire Alarm System			2007	3,034						16
17	Windsor Lighting			2008	1,556						17
18	Carpeting			2008	953						18
19	Southside Lumber			2008	1,281						19
20	Heating & Air Conditioning			2008	665						20
21	Heating & Air Conditioning			2008	1,440						21
22	Call System & Cable Installation			2009	7,220						22
23	WallCovering			2009	9,958						23
24	Carpeting			2009	1,170						24
25	Shed			2009	974						25
26	Outdoor Facility Signage			2010	2,667						26
27	Replace Door/System			2010	3,855						27
28	Sprinkler System Improvements			2010	32,932						28
29	Dining Room Tile, Paint, Hand Rails, Labor			2011	10,978						29
30	Family Room Paint, Flooring, Hand Rails, Drywall, Labor			2011	8,782						30
31	Nurse's Station Remodel			2011	6,587						31
32	Beauty Shop Paint, Flooring, Cabinet Sink Labor			2011	4,391						32
33	East Hallway Paint, Flooring, Hand Rails, Dryawall, Labor			2011	6,801						33
34	West Hallway Paint, Flooring, Hand Rails, Drywall, Labor			2011	6,801						34
35	Shower Room Renovations - Tile, Shower Heads, Fixtures, Paint			2011	3,757						35
36	Interlocking Carpet			2011	2,618						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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Prior Owner Costs (Continued):		$	$		$	$	$	37
38	3 Fire Doors for POC	2012	4,839						38
39	Replace Roof	2012	13,205						39
40	Arcoaire 5 Ton Package Unit	2012	5,580						40
41	Remodeling	2013	1,501						41
42									42
43	Bathroom Remodeling - toilets, shower heads, etc.	2014	976	57	10	57		57	43
44	Water Heater	2014	1,412	47	10	47		47	44
45	Room 16 East Hall - toilet, sink, floor remodel	2014	1,465	49	10	49		49	45
46	Room 30 West Hall - drywall, floor, lighting remodel	2014	852	21	10	21		21	46
47	Labor & Material for 5ton RTU	2014	5,864	98	10	98		98	47
48									48
49									49
50									50
51									51
52									52
53									53
54	Related Party Allocation - Bridgemark Healthcare								54
55	New Office Build-out	2011	7,677		20	407	407	1,404	55
56	Conference Room Chair Rail & Paint	2012	87		5	17	17	41	56
57									57
58	Related Party Allocation - Helia Healthcare								58
59	Water & Sewer Pipe Installation	2006	475		20	24	24	200	59
60	Pluming & Heating Installation	2006	569		20	28	28	239	60
61	A/C Unit - 4 Ton	2007	1,370		10	137	137	1,050	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 179,748	$ 272		$ 1,257	$ 985	$ 6,497	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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 8,319	$	$ 1,584	$ 1,584	7	$ 5,296	71
72	Current Year Purchases	18,499	1,144	1,340	196	7	1,340	72
73	Fully Depreciated Assets	8,081					8,081	73
74								74
75	TOTALS	$ 34,899	$ 1,144	$ 2,924	$ 1,780		$ 14,717	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										77
78	Related Party Allocation - Bridgemark			751				5	751	78
79	Related Party Allocation - Helia			1,678		24	24	5	1,678	79
80	TOTALS			$ 2,429	$	$ 24	$ 24		$ 2,429	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)	$ 218,329	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,416	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 4,205	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,789	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 23,643	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

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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		$ 84,050			3
4	Additions							4
5	Related Party Allocations				7,585			5
6	Storage Rental				100			6
7	TOTAL		57		$ 91,735 **			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 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.	/2015	$ 84,000
13.	/2016	$ 84,000
14.	/2017	$ 84,000

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: $ 5,892 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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				104		104	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				66,081		66,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					13,866		13,866	12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				199,162			199,162	13
14	TOTAL			$		$ 199,162	$ 80,051		$ 279,213	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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 3,408	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,200)	366,588		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,658		7
8	Accounts Receivable (owners or related parties)	1,530,553		8
9	Other(specify): Security Deposits	21,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,923,207	$	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	12,295		15
16	Equipment, at Historical Cost	15,178		16
17	Accumulated Depreciation (book methods)	(1,416)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	33,924		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 59,981	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,983,188	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 242,297	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,711		30
31	Accrued Taxes Payable (excluding real estate taxes)	(52)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,924		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Assessments	10,447		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 322,327	$	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	81,364		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 81,364	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 403,691	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,579,497	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,983,188	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,478,880	1
2	Restatements (describe):		2
3	**Prior year adjustments after cost report was filed**	5,145	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,484,025	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	95,472	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)**	$ 95,472	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)**	$ 1,579,497	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 2,319,057	1
2	Discounts and Allowances for all Levels	(20,314)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,298,743	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,402	6
7	Oxygen	3,455	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,857	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***	1,318	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,318	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,355,918	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	463,584	31
32	Health Care	700,575	32
33	General Administration	557,327	33
	B. Capital Expense		
34	Ownership	148,987	34
	C. Ancillary Expense		
35	Special Cost Centers	279,109	35
36	Provider Participation Fee	110,864	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,260,446	40
41	**Income before Income Taxes (line 30 minus line 40)****	95,472	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 95,472	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,161,461	44
45	Private Pay - Net Inpatient Revenue	233,130	45
46	Medicare - Net Inpatient Revenue	808,737	46
47	Other-(specify) Insurance	38,900	47
48	Other-(specify) Hospice	56,515	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,298,743	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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2,097	2,163	$ 57,205	$ 26.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,835	5,324	118,281	22.22	3
4	Licensed Practical Nurses	5,625	6,182	123,382	19.96	4
5	CNAs & Orderlies	21,562	23,305	242,948	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,886	2,105	27,416	13.02	9
10	Activity Assistants					10
11	Social Service Workers	1,897	2,098	37,177	17.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,095	7,288	75,790	10.40	15
16	Dishwashers					16
17	Maintenance Workers	1,948	2,100	48,930	23.30	17
18	Housekeepers	4,095	4,445	66,087	14.87	18
19	Laundry	1,329	1,431	14,612	10.21	19
20	Administrator	1,815	2,086	71,363	34.21	20
21	Assistant Administrator					21
22	Other Administrative	145	160	2,839	17.74	22
23	Office Manager					23
24	Clerical	646	714	12,660	17.73	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)	54,975	59,401	$ 898,690 *	$ 15.13	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		$ 4,768	1,3	35
36	Medical Director		6,000	9,3	36
37	Medical Records Consultant		296	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,260	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		3,974	11,3	44
45	Social Service Consultant		1,876	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,174		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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Misty Hargett	Administrator	0	$ 71,363
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 71,363

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 116,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 116,700

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 5,407
Ceridian	Payroll Processing	8,304
Personnel Planners, Inc	Unemployment Consultant	356
TransAmerica Retirement Solutions	Retirement Admin Fees	353
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 14,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,381
Unemployment Compensation Insurance	33,018
FICA Taxes	66,427
Employee Health Insurance	7,355
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,018
Employee Benefits	4,791
Other Employee Insurance	1,777
Related Party Allocation - Bridgemark	14,376
Related Party Allocation - Helia	6,787
TOTAL (agree to Schedule V, line 22, col.8)	$ 175,930

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	10,873
Health Care Worker Background Check	1,744
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	1,709
Late Fees	519
Miscellaneous Licenses & Fees	1,213
Related Party Allocation - Bridgemark	230
Advertising	36,942
Less: Public Relations Expense	( )
Non-allowable advertising	(36,942)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,278

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,193
Seminar Expense	1,500
Related Party Allocation - Bridgemark	3,129
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,822

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 $1,131**

(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. $ **10,873** 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. $ **110,864**
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? **No**

(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) 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. **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
12/31/2014

	Description	
16A	Nursing Equipment	4,678
16B	Copier Lease	513
16C	Dietary Equipment	576
16D	Related Party Allocation - Bridgemark Healthcare	125
		5,892