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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 10/01/03

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 01/01/16 to 12/31/16 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) Jason Mills
(Title) Director of Corporate Accounting and IT Systems

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(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' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	10,740	2,147	2,837	15,724	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,740	2,147	2,837	15,724	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.37%

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 04/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/03 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 2,234

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	88,676	5,993	4,864	99,533		99,533		99,533			1
2	Food Purchase		77,405		77,405		77,405	(52)	77,353			2
3	Housekeeping	33,368	12,516	11,749	57,633		57,633		57,633			3
4	Laundry	21,893	3,655	50,639	76,187		76,187	(5,400)	70,787			4
5	Heat and Other Utilities			37,435	37,435		37,435	(1,083)	36,352			5
6	Maintenance	53,953	14,056	37,637	105,646		105,646	12,470	118,116			6
7	Other (specify):*											7
8	TOTAL General Services	197,890	113,625	142,324	453,839		453,839	5,935	459,774			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	641,902	58,229	22,433	722,564		722,564	7,975	730,539			10
10a	Therapy		522		522		522		522			10a
11	Activities	30,715	1,809	3,685	36,209		36,209	(149)	36,060			11
12	Social Services	38,374		1,796	40,170		40,170		40,170			12
13	CNA Training											13
14	Program Transportation			1,093	1,093		1,093		1,093			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	710,991	60,560	35,007	806,558		806,558	7,826	814,384			16
	C. General Administration											
17	Administrative	75,308		132,600	207,908		207,908	(117,241)	90,667			17
18	Directors Fees											18
19	Professional Services			17,216	17,216		17,216	3,073	20,289			19
20	Dues, Fees, Subscriptions & Promotions			43,603	43,603		43,603	(25,127)	18,476			20
21	Clerical & General Office Expenses	20,572	14,485	65,607	100,664		100,664	82,555	183,219			21
22	Employee Benefits & Payroll Taxes			152,964	152,964		152,964	24,420	177,384			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,561	1,561		1,561	2,945	4,506			24
25	Other Admin. Staff Transportation			5,692	5,692		5,692	13,461	19,153			25
26	Insurance-Prop.Liab.Malpractice			43,256	43,256		43,256	2,782	46,038			26
27	Other (specify):*											27
28	TOTAL General Administration	95,880	14,485	462,499	572,864		572,864	(13,132)	559,732			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,004,761	188,670	639,830	1,833,261		1,833,261	629	1,833,890			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr #0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			7,335	7,335		7,335	2,787	10,122			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,671	43,671		43,671		43,671			32
33	Real Estate Taxes			7,301	7,301		7,301	475	7,776			33
34	Rent-Facility & Grounds			87,149	87,149		87,149	6,642	93,791			34
35	Rent-Equipment & Vehicles			5,730	5,730		5,730	467	6,197			35
36	Other (specify):*											36
37	**TOTAL Ownership**			151,186	151,186		151,186	10,371	161,557			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,446	214,388	304,834		304,834		304,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,363	101,363		101,363		101,363			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		90,446	315,751	406,197		406,197		406,197			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,004,761	279,116	1,106,767	2,390,644		2,390,644	11,000	2,401,644			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(149)	11		4
5	Telephone, TV & Radio in Resident Rooms	(4,799)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(1,430)	21		18
19	Entertainment	(972)	21		19
20	Contributions	(146)	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	(20,715)	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	(4,672)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,085)		$	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)	44,085	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,085		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 11,000		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' PREPARATION REPORT

Frankfort Hlthcr & Rehab Ctr

ID# 0046268

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	$ (3,128)	20	1
2	Eliminate Lobbying & PAC Dues	(1,486)	20	2
3	Offset Medical Records Income	(58)	10	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	(4,672)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(52)	0	0	0	0	0	0	0	0	0	0	(52)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	(5,400)	0	0	0	0	0	0	0	0	(5,400)	4
5	Heat and Other Utilities	(4,799)	109	3,607	0	0	0	0	0	0	0	0	(1,083)	5
6	Maintenance	0	0	12,470	0	0	0	0	0	0	0	0	12,470	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,851)	109	10,677	0	0	0	0	0	0	0	0	5,935	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	(58)	8,033	0	0	0	0	0	0	0	0	0	7,975	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(149)	0	0	0	0	0	0	0	0	0	0	(149)	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**	(207)	8,033	0	0	0	0	0	0	0	0	0	7,826	16
	C. General Administration													
17	Administrative	0	(117,241)	0	0	0	0	0	0	0	0	0	(117,241)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,473	600	0	0	0	0	0	0	0	0	3,073	19
20	Fees, Subscriptions & Promotions	(25,479)	352	0	0	0	0	0	0	0	0	0	(25,127)	20
21	Clerical & General Office Expenses	(2,548)	83,307	1,796	0	0	0	0	0	0	0	0	82,555	21
22	Employee Benefits & Payroll Taxes	0	12,705	11,715	0	0	0	0	0	0	0	0	24,420	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,945	0	0	0	0	0	0	0	0	0	2,945	24
25	Other Admin. Staff Transportation	0	3,780	9,681	0	0	0	0	0	0	0	0	13,461	25
26	Insurance-Prop.Liab.Malpractice	0	603	2,179	0	0	0	0	0	0	0	0	2,782	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,027)	(11,076)	25,971	0	0	0	0	0	0	0	0	(13,132)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,085)	(2,934)	36,648	0	0	0	0	0	0	0	0	629	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,018	1,769	0	0	0	0	0	0	0	0	2,787	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	11	464	0	0	0	0	0	0	0	0	475	33
34	Rent-Facility & Grounds	0	4,707	1,935	0	0	0	0	0	0	0	0	6,642	34
35	Rent-Equipment & Vehicles	0	0	467	0	0	0	0	0	0	0	0	467	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	5,736	4,635	0	0	0	0	0	0	0	0	10,371	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)**	(33,085)	2,802	41,283	0	0	0	0	0	0	0	0	11,000	45

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Champaign	Champaign, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthcare of Greenville	Greenville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Energy	Energy, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$	Bridgemark Healthcare, LLC	100.00%	$ 109	$ 109	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	8,033	8,033	2
3	V	17	Management Fees	132,600	Bridgemark Healthcare, LLC	100.00%	15,359	(117,241)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	2,473	2,473	4
5	V	20	Dues, Subcriptions		Bridgemark Healthcare, LLC	100.00%	352	352	5
6	V	21	Clerical & General Offie		Bridgemark Healthcare, LLC	100.00%	83,307	83,307	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	12,705	12,705	7
8	V	24	Tarvel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,945	2,945	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,780	3,780	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	603	603	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,018	1,018	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	11	11	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	4,707	4,707	13
14	Total			$ 132,600			$ 135,402	$ * 2,802	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 467	$ 467	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V	4	Laundry	30,075	Helia Healthcare Services	100.00%	24,675	(5,400)	21
22	V	5	Utilities		Helia Healthcare Services	100.00%	3,607	3,607	22
23	V	6	Maintenance	3,000	Helia Healthcare Services	100.00%	15,470	12,470	23
24	V	19	Professional Services		Helia Healthcare Services	100.00%	600	600	24
25	V	21	Clerical & Office Supplies		Helia Healthcare Services	100.00%	1,796	1,796	25
26	V	22	Employee Benefits & Payroll Taxes		Helia Healthcare Services	100.00%	11,715	11,715	26
27	V	25	Admin Staff Transportation		Helia Healthcare Services	100.00%	9,681	9,681	27
28	V	26	Insurance		Helia Healthcare Services	100.00%	2,179	2,179	28
29	V	30	Depreciation		Helia Healthcare Services	100.00%	1,769	1,769	29
30	V	33	Real Estate Taxes		Helia Healthcare Services	100.00%	464	464	30
31	V	34	Rent		Helia Healthcare Services	100.00%	1,935	1,935	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 33,075			$ 74,358	$ * 41,283	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	346,184	2.12	4.25	Distribution	$ 15,359	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	$ 15,359		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	370,125	13	$ 2,569	$	15,724	$ 109	1
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	189,088	15,724	8,033	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		15,724	15,359	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		15,724	2,473	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280		15,724	352	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	15,724	66,942	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		15,724	16,365	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		15,724	12,705	8
9	24	Seminars	Resident Days	370,125	13	69,325		15,724	2,945	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		15,724	3,780	10
11	26	Insurance	Resident Days	370,125	13	14,200		15,724	603	11
12	30	Depreciation	Resident Days	370,125	13	23,966		15,724	1,018	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		15,724	11	13
14	34	Building Rent	Resident Days	370,125	13	102,424		15,724	4,351	14
15	34	Rental - Storage	Resident Days	370,125	13	8,376		15,724	356	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		15,724	467	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,198,219	$ 1,764,830		$ 135,869	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 St
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	4	Laundry	Revenue	115,875	3	$ 86,447	$ 86,447	33,075	$ 24,675	1
2	5	Utilities	Revenue	115,875	3	12,637		33,075	3,607	2
3	6	Maintenance	Revenue	115,875	3	54,199	54,199	33,075	15,470	3
4	19	Professional Services	Revenue	115,875	3	2,102		33,075	600	4
5	21	Clerical & Office Supplies	Revenue	115,875	3	6,291		33,075	1,796	5
6	22	Payroll Taxes & Emp Benefits	Revenue	115,875	3	41,042		33,075	11,715	6
7	25	Other Admin Transportation	Revenue	115,875	3	33,916		33,075	9,681	7
8	26	Insurance	Revenue	115,875	3	7,635		33,075	2,179	8
9	30	Deprectiation	Revenue	115,875	3	6,197		33,075	1,769	9
10	33	Real Estate Taxes	Revenue	115,875	3	1,627		33,075	464	10
11	34	Rent	Revenue	115,875	3	6,780		33,075	1,935	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					$ 258,873	$ 140,646		$ 73,891	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	43,671	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 43,671	9
	B. Non-Facility Related*											
10	Interest Income Offset											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 43,671	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 35,994	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 7,301	2
3. Under or (over) accrual (line 2 minus line 1).		$ (28,693)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 35,994	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.		$ 7,301	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	32,989	8
	2012	32,721	9
	2013	32,936	10
	2014	32,386	11
	2015	7,301	12

7,301 Line 7, Real Estate Tax Portion of Least Payments
11 Bridgemark Healthcare Allocation
464 Helia Healthcare Allocation
7,776 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 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 Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 7,301.28	$ 7,301.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,301.28	$ 7,301.28

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/16 Ending: 12/31/16

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	$ 1,430	1
2					2
3	TOTALS			$ 1,430	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Helia Healthcare Allocation		2006	2006	$ 38,116	$	20	$ 672	$ 672	$ 4,854	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Owner Costs:										9
10	Heating and Air Conditioning			2004	4,055						10
11	Heating and Air Conditioning			2004	596						11
12	Heating and Air Conditioning			2004	416						12
13	Heating and 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 and Air Conditioning			2008	665						20
21	Heating and 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 Cabinet, Sink, 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, Drywall, 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.

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	3 Fire Doors for POC	2012	$ 4,839	$		$	$	$	37
38	Replace Roof	2012	13,205						38
39	Arcoaire 5 Ton Package Unit	2012	5,580						39
40	Remodeling	2013	1,501						40
41									41
42	Bathroom Remodleing - toilets showerheads, etc	2014	976	98	10	98		252	42
43	Water Heater	2014	1,412	141	10	141		329	43
44	Room 16 east Hall - toilet, sink, floor, remodel	2014	1,465	147	10	147		342	44
45	Room 30 West Hall - drywall, floor, lighting, remodel	2014	852	85	10	85		191	45
46	Labor & Material for 5 ton RTU	2014	5,864	586	10	586		1,270	46
47	Lights, Paint, Flooring for resident room A-Wing	2015	5,085	339	15	339		593	47
48	Sewage Pipe Replacement	2015	8,400	420	20	420		490	48
49	A/C Unit	2016	6,526	381	10	381		381	49
50	Roof Repairs	2016	3,790	189	10	189		189	50
51									51
52									52
53									53
54									54
55									55
56	Related Party Allocation - Bridgemark Healthcare LLC								56
57	New Office Build-Out	2011	5,770		20	306	306	1,666	57
58	Conference Room Chair Rail & Paint	2012	65		5	13	13	57	58
59									59
60									60
61	Related Pary Allocation - Helia Healthcare								61
62	Water & Sewer Pipe Installation	2006	542		20	27	27	282	62
63	Plumbing & Heating Installation	2006	649		20	33	33	339	63
64	A/C Unit - 4 Ton	2007	1,564		10	156	156	1,512	64
65	400 Gal. Water Storage Tank	2016	4,414		10	184	184	184	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 237,041	$ 2,386		$ 3,777	$ 1,391	$ 12,931	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 36,589	$ 4,897	$ 5,794	$ 897	3-15	$ 13,474	71
72	Current Year Purchases	8,857	52	551	499	3-15	551	72
73	Fully Depreciated Assets	12,317					12,317	73
74								74
75	TOTALS	$ 57,763	$ 4,949	$ 6,345	$ 1,396		$ 26,342	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Related Party Allocation - Bridgemark		2005	565				4	565	77
78	Related Party Allocation - Helia		2006	1,916				4	1,916	78
79										79
80	TOTALS			$ 2,481	$	$	$		$ 2,481	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)	$ 298,715	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,122	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,787	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 41,754	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 86,185			3
4	Additions							4
5	Related Party Allocations				6,642			5
6	Storage Rental				964			6
7	TOTAL		57		$ 93,791 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A .
   N/A
   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.	/2017	$ 84,000
13.	/2018	$ 84,000
14.	/2019	$ 84,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 6,197 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' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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				522		522	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				70,861		70,861	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					19,584		19,584	12
13	Other (specify): X-Ray, Labs, Therapy	39,3				214,388			214,388	13
14	TOTAL			$		$ 214,388	$ 90,967		$ 305,355	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr **#** 0046268 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 3,210	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 45,766)	1,020,790		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	488		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	917,149		8
9	Other(specify): Deposits	21,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,962,637	$	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	44,305		15
16	Equipment, at Historical Cost	22,794		16
17	Accumulated Depreciation (book methods)	(14,494)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	63,634		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 116,239	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,078,876	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 364,788	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,234		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,994		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Fees	9,659		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 464,110	$	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)**	$ 545,474	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,533,402	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,078,876	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,409,416	1
2	Restatements (describe):		2
3	**Prior Year Adjustments made after Cost Report Issued**	(148,927)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,260,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	272,913	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)**	$ 272,913	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)**	$ 1,533,402	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 2,610,978	1
2	Discounts and Allowances for all Levels	(10,002)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,600,976	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,893	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 60,893	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	149	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)**	$ 149	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records	58	28
28a	Miscellaneous	1,481	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,539	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,663,557	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	453,839	31
32	Health Care	806,558	32
33	General Administration	572,864	33
	B. Capital Expense		
34	Ownership	151,186	34
	C. Ancillary Expense		
35	Special Cost Centers	304,834	35
36	Provider Participation Fee	101,363	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,390,644	40
41	**Income before Income Taxes (line 30 minus line 40)****	272,913	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 272,913	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,308,234	44
45	Private Pay - Net Inpatient Revenue	292,965	45
46	Medicare - Net Inpatient Revenue	921,880	46
47	Other-(specify) Insurance	47,348	47
48	Other-(specify) Hospice	30,549	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,600,976	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,999	2,125	$ 61,401	$ 28.89	1
2	Assistant Director of Nursing	1,862	1,975	49,834	25.23	2
3	Registered Nurses	5,775	6,172	148,122	24.00	3
4	Licensed Practical Nurses	3,673	3,852	75,776	19.67	4
5	CNAs & Orderlies	26,812	28,258	306,769	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	2,202	30,715	13.95	9
10	Activity Assistants					10
11	Social Service Workers	1,997	2,137	38,374	17.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,586	7,931	88,676	11.18	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,146	53,953	25.14	17
18	Housekeepers	3,558	3,760	33,368	8.87	18
19	Laundry	1,935	2,139	21,893	10.24	19
20	Administrator	2,019	2,143	75,308	35.14	20
21	Assistant Administrator					21
22	Other Administrative	569	609	20,572	33.78	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)	61,616	65,449	$ 1,004,761 *	$ 15.35	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		$ 4,864	1,3	35
36	Medical Director		6,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,507	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		3,685	11,3	44
45	Social Service Consultant		1,796	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,852		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' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan M. Williams	Adminstrator	0	$ 75,308
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,308

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC - Management Fees	$ 132,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 132,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting Services	$ 3,775
Paycom Payroll, LLC	Payroll Processing	6,483
Personnel Planners, Inc.	Unemployment Consulting	1,232
Allen A Lefkovitz & Assoc	Legal Fees - R.E. Tax Appeal	5,607
Ashman & Stein	Legal - Notice of Defaults	119
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 17,216

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,862
Unemployment Compensation Insurance	26,262
FICA Taxes	73,518
Employee Health Insurance	13,621
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	1,626
Employee Benefits	75
Other Employee Insurance	
Related Party Allocation - Bridgemark	12,705
Related Party Allocation - Helia	11,715
TOTAL (agree to Schedule V, line 22, col.8)	$ 177,384

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

Description	Line #	Amount
Secdtion N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,641
Health Care Worker Background Check	2,119
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	2,276
Late Fees	4,821
Miscellaneous Licenses & Fees	277
Advertising	20,715
Related Party Allocation - Bridgemark	352
Less: Public Relations Expense	( )
Non-allowable advertising	(20,715)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,476

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	106
Seminar Expense	1,455
Related Party Allocation - Bridgemark	2,945
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,506

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Hlthcr & Rehab Ctr # 0046268 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $2,276**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,008** 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. $ **101,363**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **149**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Frankfort Healthcare & Rehab Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

	Description	
16A	Nursing Equipment	4,295
16B	Copier Lease	968
16C	Related Party Allocation - Bridgemark Healthcare	467
16D	Dietary Equipment	467
		6,197