

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0045187

Facility Name: FARMINGTON COUNTRY MANOR

Address: 701 S MAIN ST FARMINGTON 61531
Number City Zip Code

County: FULTON

Telephone Number: (309) 245-2407 Fax # (309) 245-2420

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1995

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☒ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: ROBERT CONNER Telephone Number: (610) 832-2059
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 01/01/2012 to 12/31/2012 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)
(Type or Print Name) ROBERT CONNER
(Title) CHIEF FINANCIAL OFFICER

Paid
Preparer

(Signed)
(Print Name and Title) BART MCCURLEY CPA
(Firm Name & Address) SELF, MAPLES & COPELAND, P.C.
1601 SECOND AVENUE EAST, ONEONTA, AL 35121
(Telephone) (205) 625-3472 Fax # (205) 274-0182

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 FARMINGTON COUNTRY MANOR# 0045187 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,759</u>	<u>13,227</u>	<u>3,537</u>	<u>27,523</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,759</u>	<u>13,227</u>	<u>3,537</u>	<u>27,523</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.96%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

N/A

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/01/1995

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 12/01/1995NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 92 and days of care provided 1,979Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	205,180	20,993	13,654	239,827		239,827		239,827		1
2	Food Purchase		179,934		179,934		179,934	(428)	179,506		2
3	Housekeeping	119,384	19,746		139,130		139,130		139,130		3
4	Laundry	62,435	24,748		87,183		87,183		87,183		4
5	Heat and Other Utilities			98,843	98,843		98,843		98,843		5
6	Maintenance	64,600	34,155	23,177	121,932		121,932		121,932		6
7	Other (specify):*										7
8	TOTAL General Services	451,599	279,576	135,674	866,849		866,849	(428)	866,421		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,403,163	101,326	15,220	1,519,709		1,519,709		1,519,709		10
10a	Therapy		1,173	268,100	269,273		269,273		269,273		10a
11	Activities	47,940	6,963	875	55,778		55,778		55,778		11
12	Social Services	41,424			41,424		41,424		41,424		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,492,527	109,462	296,195	1,898,184		1,898,184		1,898,184		16
	C. General Administration										
17	Administrative	92,631		357,759	450,390		450,390	(112,641)	337,749		17
18	Directors Fees										18
19	Professional Services			19,825	19,825		19,825	40,855	60,680		19
20	Dues, Fees, Subscriptions & Promotions			23,609	23,609		23,609	(16,412)	7,197		20
21	Clerical & General Office Expenses	167,866	11,828	167,428	347,122		347,122	(118,560)	228,562		21
22	Employee Benefits & Payroll Taxes			376,451	376,451		376,451	37,904	414,355		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,121	4,121		4,121		4,121		24
25	Other Admin. Staff Transportation			10,656	10,656		10,656		10,656		25
26	Insurance-Prop.Liab.Malpractice			44,615	44,615		44,615		44,615		26
27	Other (specify):*										27
28	TOTAL General Administration	260,497	11,828	1,004,464	1,276,789		1,276,789	(168,854)	1,107,935		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,204,623	400,866	1,436,333	4,041,822		4,041,822	(169,282)	3,872,540		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			149,502	149,502		149,502	47	149,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			244,605	244,605	(12,228)	232,377	(1,400)	230,977			32
33	Real Estate Taxes			54,602	54,602		54,602		54,602			33
34	Rent-Facility & Grounds							8,605	8,605			34
35	Rent-Equipment & Vehicles			16,281	16,281		16,281		16,281			35
36	Other (specify):* Mortgage Ins					12,228	12,228		12,228			36
37	TOTAL Ownership			464,990	464,990		464,990	7,252	472,242			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,869	78,821	83,690		83,690		83,690			39
40	Barber and Beauty Shops		434		434		434		434			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			216,541	216,541		216,541		216,541			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,303	295,362	300,665		300,665		300,665			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,204,623	406,169	2,196,685	4,807,477		4,807,477	(162,030)	4,645,447			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 FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,564)	21		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	(1,400)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(428)	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(116,371)	21		24
25	Fund Raising, Advertising and Promotional	(16,412)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,175)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (145,175)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
FARMINGTON COUNTRY MANOR

Report Period Beginning: ID# 0045187
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(428)	0	0	0	0	0	0	0	0	0	0	(428)	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(428)	0	0	0	0	0	0	0	0	0	0	(428)	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(112,641)	0	0	0	0	0	0	0	0	0	(112,641)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	40,855	0	0	0	0	0	0	0	0	0	40,855	19
20	Fees, Subscriptions & Promotions	(16,412)	0	0	0	0	0	0	0	0	0	0	(16,412)	20
21	Clerical & General Office Expenses	(126,935)	8,375	0	0	0	0	0	0	0	0	0	(118,560)	21
22	Employee Benefits & Payroll Taxes	0	37,904	0	0	0	0	0	0	0	0	0	37,904	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(143,347)	(25,507)	0	0	0	0	0	0	0	0	0	(168,854)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(143,775)	(25,507)	0	0	0	0	0	0	0	0	0	(169,282)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	47	0	0	0	0	0	0	0	0	0	47	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,400)	0	0	0	0	0	0	0	0	0	0	(1,400)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,605	0	0	0	0	0	0	0	0	0	8,605	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,400)	8,652	0	0	0	0	0	0	0	0	0	7,252	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)	(145,175)	(16,855)	0	0	0	0	0	0	0	0	0	(162,030)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH CORPORATION	100	OAK TRACE	ALABAMA			
AMERICAN HEALTH CORPORATION	100	TERRACE OAKS	ALABAMA			
AMERICAN HEALTH CORPORATION	100	COLONIAL HAVEN	ALABAMA			
AMERICAN HEALTH CORPORATION	100	RAINBOW OF NEW JERSEY, INC.	NEW JERSEY			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	\$ 13,654	AMERICAN HEALTH CORPORATION	100.00%	\$ 13,654	\$	1
2	V	17	ADMINISTRATIVE	357,759	AMERICAN HEALTH CORPORATION	100.00%	245,118	(112,641)	2
3	V	19	PROFESSIONAL SERVICES		AMERICAN HEALTH CORPORATION	100.00%	40,855	40,855	3
4	V	21	CLERICAL & GEN OFFICE		AMERICAN HEALTH CORPORATION	100.00%	8,375	8,375	4
5	V	22	EMP BENEFITS & P/R TAXES		AMERICAN HEALTH CORPORATION	100.00%	37,904	37,904	5
6	V	34	RENT - FACILITY		AMERICAN HEALTH CORPORATION	100.00%	8,605	8,605	6
7	V	30	DEPRECIATION		AMERICAN HEALTH CORPORATION	100.00%	47	47	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 371,413			\$ 354,558	\$ * (16,855)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STANLEY STEIN	CEO	ADMINISTRATIV	23.89		10	25.00	MGMT FEE	\$ 81,450	17-8	1
2	GARY STEIN	VICE PRESIDENT	ADMINISTRATIV	0.00		10	25.00	MGMT FEE	35,757	17-8	2
3	JODI STEIN	ADMIN ASST	ADMINISTRATIV	0.00		10	25.00	MGMT FEE	10,705	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 127,912		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 FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization AMERICAN HEALTH CORPORATION
Street Address 527 PLYMOUTH ROAD, SUITE 412
City / State / Zip Code PLYMOUTH MEETING, PA 19462
Phone Number (610) 832-2059
Fax Number (610) 834-2937

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DAYS	126,777	4	\$ 1,053,293	\$ 808,052	29,503	\$ 245,118	1
2	19	PROFESSIONAL SERVICES	DAYS	126,777	4	175,558		29,503	40,855	2
3	21	CLERICAL & GEN OFFICE	DAYS	126,777	4	35,986		29,503	8,375	3
4	22	EMP BEN & P/R TAXES	DAYS	126,777	4	162,875		29,503	37,904	4
5	34	RENT - FACILITY	DAYS	126,777	4	36,976		29,503	8,605	5
6	30	DEPRECIATION	DAYS	126,777	4	202		29,503	47	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	TOTALS					\$ 1,464,890	\$ 808,052		\$ 340,904	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	BERKADIA COMM MORT		X	LAND, BUILDING, EQUIP	\$31,452.00		\$ 3,017,500	\$ 2,965,038	03/01/2029	6.1500	\$ 231,958	1	
2	BANK OF FARMINGTON		X	EQUIPMENT	\$698.21	2007	45,133	1,384		4.0000	419	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$32,150.21		\$ 3,062,633	\$ 2,966,422			\$ 232,377	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,062,633	\$ 2,966,422			\$ 232,377	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,228 Line # 32-3

* 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	51,386	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.)				\$	52,994	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	1,608	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	52,994	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.				\$	54,602	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	2007	53,004	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>				FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2008	47,780	9																							
	2009	50,298	10																							
	2010	50,509	11																							
	2011	51,386	12																							
REAL ESTATE TAX ACCRUAL BASED ON PRIOR AMOUNT DUE TO TAXING AUTHORITY.																										

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

FARMINGTON COUNTRY MANOR

COUNTY

FULTON

FACILITY IDPH LICENSE NUMBER

0045187

CONTACT PERSON REGARDING THIS REPORT

ROBERT CONNER, CFO

TELEPHONE

(610) 832-2059

FAX #:

(610) 834-2937

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	05-04-12-300-013	LAND & BUILDING	\$ 52,138.34	\$ 52,138.34
2.	05-04-12-300-002	LAND & BUILDING	\$ 669.70	\$ 669.70
3.	05-04-12-300-017	LAND & BUILDING	\$ 19.16	\$ 19.16
4.	05-04-12-300-016	LAND & BUILDING	\$ 167.20	\$ 167.20
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 52,994.40	\$ 52,994.40

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

A. Square Feet:

33,000

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING FACILITY		7/28/1986	\$ 34,115	1
2					2
3	TOTALS			\$ 34,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FARMINGTON COUNTRY MANOR

0045187

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92		1986		\$	\$		\$	\$		4
5					2,264,583	75,486	30	75,486		2,001,469	5
6											6
7											7
8											8
	Improvement Type**										
9	1987 ADDITIONS			1987	2,769	49	25	49		2,769	9
10	1988 ADDITIONS			1988	50,953	1,674	VARIOUS	1,674		43,692	10
11	1989 ADDITIONS			1989	36,365	144	VARIOUS	144		35,391	11
12	1990 ADDITIONS			1990	11,397		15			11,397	12
13	1991 ADDITIONS			1991	41,089		15			41,089	13
14	1992 ADDITIONS			1992	4,778		15			4,778	14
15	1993 ADDITIONS			1993	4,673		15			4,673	15
16	1994 ADDITIONS			1994	17,596		15			16,921	16
17	1995 ADDITIONS			1995	1,742		15			1,742	17
18	CARPET			2001	300		3			300	18
19											19
20	ROOF			2003	28,208	723	39	723		6,870	20
21	PAVING PARKING LOT			2003	41,839	2,791	15	2,791		31,092	21
22	PARKING LOT			2006	4,890	125	39	125		776	22
23	PAVING /BLACKTOPPING			2007	4,250	109	39	109		631	23
24	ROOF			2008	41,366	2,759	15	2,759		12,413	24
25											25
26	VENTING			2009	22,548	578	39	578		1,951	26
27	BLINDS AND WINDOW TREATMENTS			2009	5,132	132	39	132		401	27
28	DINING ROOM FLOOR			2009	19,295	495	39	495		1,506	28
29	VENTING MATERIALS			2009	1,582	41	39	41		125	29
30	LEASEHOLD IMPROVEMENT			2010	1,122	160	7	160		400	30
31	NURSE CALL STATION			2010	4,600	307	15	307		767	31
32	NURSE CALL STATION			2010	21,546	1,436	15	1,436		3,589	32
33	CARPET			2010	1,927	275	7	275		688	33
34											34
35	NURSING HALLWAY - FLOOR TILES			2011	1,319	34	39	34		64	35
36											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

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	OUTSIDE - SEAL COATING, BENCHES, LANDSCAPING ROC	2012	\$ 9,754	\$ 136	39	\$ 136	\$	\$ 136	37
38	OUTSIDE - CONCRETE INSTALLATION, FENCING, SIGN	2012	11,473	160	39	160		160	38
39	THERAPY ROOM FLOORING	2012	3,494	41	39	41		41	39
40	ARCHITECT FEES FOR THERAPY ROOM	2012	1,954	2	39	2		2	40
41	SHOWER ROOMS UPGRADE	2012	25,250	27	39	27		27	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,687,794	\$ 87,684		\$ 87,684	\$	\$ 2,225,860	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 793,779	\$ 42,860	\$ 42,860	\$		\$ 700,302	71
72	Current Year Purchases	202,337	14,446	14,446			14,472	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 996,116	\$ 57,306	\$ 57,306	\$		\$ 714,774	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	NURSING FACILITY VAN	VAN	2007	\$ 45,133	\$ 4,512	\$ 4,512	\$	5	\$ 45,133	76
77										77
78										78
79										79
80	TOTALS			\$ 45,133	\$ 4,512	\$ 4,512	\$		\$ 45,133	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,763,158	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 149,502	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 149,502	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,985,767	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending

Annual Rent

12. /2013 \$
13. /2014 \$
14. /2015 \$

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.

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 16,281
- Description: NURSING EQUIPMENT - \$4,360, DIETARY EQUIPMENT - \$1,085, ADMIN EQUIPMENT - \$10,836
- (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			\$	\$	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

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

☒ 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

C. CONTRACTUAL INCOME

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)	\$			

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

HFS 3745 (N-4-99)

IL478-2471

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

12345678										
	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	10A-3	hrs	\$	1,353	\$ 84,702	\$	1,353	\$ 84,702	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,748	67,842		1,748	67,842	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,692	115,556	1,173	1,692	116,729	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				57,304		57,304	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39					4,869		4,869	12
13	Other (specify): RADIOLOGY	39					2,788		2,788	13
14	TOTAL			\$	4,793	\$ 268,100	\$ 66,134	4,793	\$ 334,234	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

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	\$ 199,270	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27)	631,491		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,485		6
7	Other Prepaid Expenses	6,756		7
8	Accounts Receivable (owners or related parties)	3,458,927		8
9	Other(specify):	(26,289)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,272,640	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,115		13
14	Buildings, at Historical Cost	2,264,583		14
15	Leasehold Improvements, at Historical Cost	423,190		15
16	Equipment, at Historical Cost	1,041,251		16
17	Accumulated Depreciation (book methods)	(2,985,767)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	389,320		21
22	Other Long-Term Assets (specify) <u>LOAN COST</u>	190,864		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,357,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,630,196	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 202,279	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	78,484		29
30	Accrued Salaries Payable	133,620		30
31	Accrued Taxes Payable (excluding real estate taxes)	135,816		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,994		32
33	Accrued Interest Payable	9,530		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>ACCRUED UTILITIES</u>	1,185		36
37	<u>DUE TO IL PUBLIC AID</u>	118,430		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 732,338	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,887,938		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,887,938	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,620,276	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,009,920	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,630,196	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,904,777	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,904,777	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,143	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)	\$ 105,143	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)	\$ 2,009,920	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 4,957,625	1	
2Discounts and Allowances for all Levels	(639,811)	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,317,814	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy	393,905	6	
7Oxygen	23,098	7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 417,003	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs	57,206	17	
18Sale of Supplies to Non-Patients		18	
19Laboratory	(1,881)	19	
20Radiology and X-Ray		20	
21Other Medical Services	121,078	21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 176,403	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	1,400	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,400	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,912,620	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	866,849	31	
32Health Care	1,898,184	32	
33General Administration	1,276,789	33	
B. Capital Expense			
34Ownership	464,990	34	
C. Ancillary Expense			
35Special Cost Centers	84,124	35	
36Provider Participation Fee	216,541	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,807,477	40	
41Income before Income Taxes (line 30 minus line 40)**	105,143	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 105,143	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$ 1,811,895	44	
45Private Pay - Net Inpatient Revenue	2,185,290	45	
46Medicare - Net Inpatient Revenue	321,860	46	
47Other-(specify) HOSPICE	523,930	47	
48Other-(specify) INSURANCE	114,650	48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,957,625	49	

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,856	2,304	\$ 77,049	\$ 33.44	1
2	Assistant Director of Nursing	297	479	8,648	18.05	2
3	Registered Nurses	9,254	11,280	247,427	21.94	3
4	Licensed Practical Nurses	18,455	22,945	469,087	20.44	4
5	CNAs & Orderlies	50,872	60,815	571,890	9.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,902	2,258	32,745	14.50	9
10	Activity Assistants	1,659	2,174	15,195	6.99	10
11	Social Service Workers	1,902	2,398	41,424	17.27	11
12	Dietician					12
13	Food Service Supervisor	1,836	2,324	39,873	17.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,440	18,266	165,307	9.05	15
16	Dishwashers					16
17	Maintenance Workers	3,479	4,666	64,600	13.84	17
18	Housekeepers	10,308	12,834	119,384	9.30	18
19	Laundry	5,493	6,081	62,435	10.27	19
20	Administrator	1,824	2,336	92,631	39.65	20
21	Assistant Administrator					21
22	Other Administrative	5,326	6,769	125,524	18.54	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	1,794	2,328	42,342	18.19	31
32	Other Health Care CENTRAL SUPPLY	1,746	2,466	29,062	11.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,443	162,723	\$ 2,204,623 *	\$ 13.55	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	288	\$ 13,654	1-3	35
36	Medical Director	96	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	295	6,516	10-3	38
39	Pharmacist Consultant	192	5,822	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	16	875	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	887	\$ 38,867		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number

FARMINGTON COUNTRY MANOR

0045187

Report Period Beginning:

01/01/2012

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Ending:

12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JENNIFER BAKER	ADMINISTRATOR	0	\$ 92,631	Workers' Compensation Insurance	\$ 78,177	IDPH License Fee	\$ 300	
				Unemployment Compensation Insurance	28,520	Advertising: Employee Recruitment		
				FICA Taxes	163,256	Health Care Worker Background Check		
				Employee Health Insurance	91,130	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		MARKETING	16,412	
				EMPLOYEE ACTIVITIES	15,368	IHCA DUES	5,078	
				HLTH INS & TAXES FROM CENTRAL OFFICE	37,904	OTHER DUES & SUBSCRIPTIONS	1,819	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 92,631					
B. Administrative - Other								
Description			Amount					
AMERICAN HEALTH CORPORATION			\$ 357,759			Less: Public Relations Expense	()	
						Non-allowable advertising	(16,412)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 357,759	TOTAL (agree to Schedule V,	\$ 414,355	TOTAL (agree to Sch. V,	\$ 7,197	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
NERDS ON CALL	DATA PROCESSING		\$ 8,310				Out-of-State Travel	
NTT DATA LTC SOLUTIONS	DATA PROCESSING		6,725					
FROELING, WEBBER, EVANS	LEGAL		1,040					
SELF, MAPLES, & COPELAND	ACCOUNTING		3,750				In-State Travel	
							ADMIN TRAVEL	
							Seminar Expense	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,825				line 24, col. 8)	
							TOTAL	
							\$ 4,121	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$5078.40

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A

(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?

7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 35,258

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 216,541

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

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

YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

NO

Indicate the amount. \$ 0

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

YES

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?

0

d. Have vehicle usage logs been maintained?

YES

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

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:

NOT REQUIRED

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

YES

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.