

		FOR BHF USE					

LL1

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: <u>0045583</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Friendship Manor of St. Elmo</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.																																																	
Address: <u>221 East Cumberland</u> <u>St. Elmo</u> <u>62458</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Fayette</u>																																																			
Telephone Number: <u>(618) 829-5881</u> Fax # <u>(618) 829-5569</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>03/01/1999</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>John Knoblett, CPA</u>																																																			
Telephone Number: <u>(217) 351-2073</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>William R. Gillis</u>																																																	
		(Title) <u>President</u>																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>John Knoblett, CPA</u> <u>Partner</u>																																																	
		(Firm Name & Address) <u>Kemper CPA Group LLP</u> <u>1701 Broadmoor Drive, Suite 120</u>																																																	
		(Telephone) <u>(217) 351-2073</u> Fax # <u>(217) 351-3487</u>																																																	
		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 Friendship Manor of St. Elmo

0045583 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	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>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>18</u>	Intermediate (ICF)	<u>18</u>	<u>6,570</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,900</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>10,789</u>	<u>4,044</u>	<u>2,747</u>	<u>17,580</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>10,789</u>	<u>4,044</u>	<u>2,747</u>	<u>17,580</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.27%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department?
131 (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)
Day Care, Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 03/01/1999

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/26/1999 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 42 and days of care provided 2,747

Medicare Intermediary _____

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.

Facility Name & ID Number Friendship Manor of St. Elmo # 0045583 Report Period Beginning: 01/01/12 Ending: 12/31/12
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	113,294	14,223	5,697	133,214		133,214		133,214			1
2	Food Purchase		122,923		122,923		122,923	(5,679)	117,244			2
3	Housekeeping	67,722	27,681		95,403		95,403		95,403			3
4	Laundry	33,290	10,650		43,940		43,940		43,940			4
5	Heat and Other Utilities			50,646	50,646		50,646		50,646			5
6	Maintenance	24,812	3,349	38,485	66,646		66,646		66,646			6
7	Other (specify):*											7
8	TOTAL General Services	239,118	178,826	94,828	512,772		512,772	(5,679)	507,093			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	861,174	39,982	1,994	903,150		903,150		903,150			10
10a	Therapy		48	223,447	223,495		223,495		223,495			10a
11	Activities	34,118	395	2,269	36,782		36,782		36,782			11
12	Social Services	37,734		2,269	40,003		40,003		40,003			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	933,026	40,425	239,579	1,213,030		1,213,030		1,213,030			16
	C. General Administration											
17	Administrative	76,349		144,000	220,349	(75,458)	144,891	(24,382)	120,509			17
18	Directors Fees											18
19	Professional Services			17,073	17,073	1,601	18,674		18,674			19
20	Dues, Fees, Subscriptions & Promotions			15,770	15,770		15,770	(5,909)	9,861			20
21	Clerical & General Office Expenses	13,606		41,103	54,709	60,485	115,194	(21,277)	93,917			21
22	Employee Benefits & Payroll Taxes			187,382	187,382	7,733	195,115		195,115			22
23	Inservice Training & Education			725	725		725		725			23
24	Travel and Seminar			5,789	5,789	704	6,493	(1,716)	4,777			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,292	50,292	324	50,616		50,616			26
27	Other (specify):*											27
28	TOTAL General Administration	89,955		462,134	552,089	(4,611)	547,478	(53,284)	494,194			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,262,099	219,251	796,541	2,277,891	(4,611)	2,273,280	(58,963)	2,214,317			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			35,365	35,365	8,625	43,990		43,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			964	964	8,462	9,426	(1,839)	7,587			32
33	Real Estate Taxes			20,515	20,515		20,515		20,515			33
34	Rent-Facility & Grounds			102,000	102,000	(12,611)	89,389	(89,389)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			158,844	158,844	4,476	163,320	(91,228)	72,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			97,567	97,567		97,567	175	97,742			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,474	124,474		124,474		124,474			42
43	Other (specify):*			85	85	135	220	(220)				43
44	TOTAL Special Cost Centers			222,126	222,126	135	222,261	(45)	222,216			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,262,099	219,251	1,177,511	2,658,861		2,658,861	(150,236)	2,508,625			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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,539)	2		4
5	Telephone, TV & Radio in Resident Rooms				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	(1,839)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(140)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	175	39		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,716)	24		19
20	Contributions	(220)	43		20
21	Owner or Key-Man Insurance	(1,525)	17		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,175)	21		24
25	Fund Raising, Advertising and Promotional	(5,909)	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 See Page 5A	(1,102)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,990)		\$	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)	(112,246)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (112,246)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (150,236)		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.			\$		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (1,102)	21	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	(1,102)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor of St. Elmo # 0045583 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,679)	0	0	0	0	0	0	0	0	0	0	(5,679)	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	(5,679)	0	0	0	0	0	0	0	0	0	0	(5,679)	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	(1,525)	(22,857)	0	0	0	0	0	0	0	0	0	(24,382)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,909)	0	0	0	0	0	0	0	0	0	0	(5,909)	20
21	Clerical & General Office Expenses	(21,277)	0	0	0	0	0	0	0	0	0	0	(21,277)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,716)	0	0	0	0	0	0	0	0	0	0	(1,716)	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	(30,427)	(22,857)	0	0	0	0	0	0	0	0	0	(53,284)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(36,106)	(22,857)	0	0	0	0	0	0	0	0	0	(58,963)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor of St. Elmo # 0045583 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Capital Expense	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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,839)	0	0	0	0	0	0	0	0	0	0	(1,839)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(89,389)	0	0	0	0	0	0	0	0	0	(89,389)	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	(1,839)	(89,389)	0	0	0	0	0	0	0	0	0	(91,228)	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	175	0	0	0	0	0	0	0	0	0	0	175	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):*	(220)	0	0	0	0	0	0	0	0	0	0	(220)	43
44	TOTAL Special Cost Centers	(45)	0	0	0	0	0	0	0	0	0	0	(45)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(37,990)	(112,246)	0	0	0	0	0	0	0	0	0	(150,236)	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
See Next Page						

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	17	Management Fees	\$ 144,000	Rincker Healthcare Corporation	100.00%	\$ 121,143	\$ (22,857)	1
2	V	34	Rent	102,000	William Rincker Trust		12,611	(89,389)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 246,000			\$ 133,754	\$ * (112,246)	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	Angela West Trust	25%	West Grove, Inc.	Lawrenceville				1
2	Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport				2
3	Angela West Trust	20%	Lawrence Community Healthcare Center	Bridgeport				3
4	Mary Jane Rincker Trust	25%	West Grove, Inc.	Lawrenceville				4
5	Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport				5
6	Mary Jane Rincker Trust	20%	Lawrence Community Healthcare Center	Bridgeport				6
7	Deanna Gillis Trust	25%	West Grove, Inc.	Lawrenceville				7
8	Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport				8
9	Deanna Gillis Trust	20%	Lawrence Community Healthcare Center	Bridgeport				9
10	William J. Rincker Trust	25%	West Grove, Inc.	Lawrenceville				10
11	William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport				11
12	William J. Rincker Trust	20%	Lawrence Community Healthcare Center	Bridgeport				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St. Elmo # 0045583 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1 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	William J. Rincker		Administration	0.25	25,598	9	0.25	Wages	\$ 7,402	17-1	1
2	Angela West		Administration	0.25	25,598	9	0.25	Wages	7,402	17-1	2
3	Deanna Gillis		Administration	0.25	46,634	1	0.10	Wages	8,974	17-1	3
4	Jane Rincker	Accounting Supr.	Bookkeeping	0.25	149,689	10	0.25	Wages	43,284	21-1	4
5	William R. Gillis	President	Administration		165,011	1	0.03	Wages	15,970	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 83,032		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 Friendship Manor of St. Elmo # 0045583 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Rincker Healthcare Corporation
Street Address 900 East Corporation
City / State / Zip Code Bridgeport, IL 62417
Phone Number (618) 945-2091
Fax Number (618) 945-9030

	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	<u>See Attached Schedule Pg 25</u>				\$	\$		\$	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	TOTALS				\$	\$		\$	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	First Financial Bank NA		X	Van Loan	\$765.00	08/03/09	\$ 37,202	\$ 11,706	04/15/14	5.9900	\$ 964	1	
2	First Financial Bank NA		X	Refinance Purchase	\$5,420.02	01/11/07	357,666	54,134	01/15/14	4.6000	3,986	2	
3	First Financial Bank NA		X	Rincker Healthcare - Auto	\$1,170.13	03/30/10	62,000	13,586	03/10/15	5.0000	207	3	
4												4	
5												5	
	Working Capital												
6	First Financial Bank NA		X	Rincker Healthcare - LOC	n/a	12/21/12	2,000,000	180,000	11/01/13	3.2500	4,269	6	
7												7	
8												8	
9	TOTAL Facility Related				\$7,355.15		\$ 2,456,868	\$ 259,426			\$ 9,426	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,456,868	\$ 259,426			\$ 9,426	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* 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

[illegible]

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

FACILITY NAME Friendship Manor of St. Elmo COUNTY Fayette
FACILITY IDPH LICENSE NUMBER 0045583
CONTACT PERSON REGARDING THIS REPORT John Knobblett, CPA
TELEPHONE (217) 351-2073 FAX #: (217) 351-3487

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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-12-27-237-002</u>	<u>Land</u>	\$ <u>72.44</u>	\$ <u>72.44</u>
2. <u>01-12-27-237-003</u>	<u>Building & Land</u>	\$ <u>18,398.44</u>	\$ <u>18,398.44</u>
3. <u>01-12-27-237-004</u>	<u>Building & Land</u>	\$ <u>1,468.63</u>	\$ <u>1,468.63</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>19,939.51</u>	\$ <u>19,939.51</u>

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 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.)

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: 14,076

B. General Construction Type: Exterior BrickFrame Reinforced ConcreteNumber 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).

N/A

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	Facility	51,830	1999	\$ 5,000	1
2			2003	4,000	2
3	TOTALS	51,830		\$ 9,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60		1999	1672	\$ 345,000	\$ 8,625	40	\$ 8,625	\$	\$ 119,313
5			2003	1936	40,000	1,003	40	1,003		9,368
6										
7										
8										
	Improvement Type**									
9	Painting and Wallpapering			1999	5,350					5,350
10	Sidewalk			1999	798					798
11	Dish Tables			2002	1,744	29	10	29		1,744
12	Central Air System for Kitchen			2002	4,250	142	10	142		4,250
13	Flooring			2003	2,375	164	10	164		2,375
14	Commercial Water Heater			2005	4,663	466	10	466		3,653
15	New Flooring			2008	4,948	495	10	495		2,474
16	Water Heater			2008	6,558	656	10	656		3,279
17	Water Heater			2008	6,308	631	10	631		2,576
18	Electrical Upgrade			2010	3,914	196	20	196		408
19	Sprinkler System Rennovation			2011	23,728	949	25	949		1,265
20	New Sliding Door			2012	3,805	152	25	152		152
21	New Fire Alarm			2012	3,500	73	20	73		73
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St. Elmo

0045583

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									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)		\$ 456,941	\$ 13,581		\$ 13,581	\$	\$ 157,078	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	\$292,558	\$20,395	\$20,395	\$	3-15 Yrs	\$260,551	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	23,148					23,148	73
74								74
75	TOTALS	\$315,706	\$20,395	\$20,395	\$		\$283,699	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	Transport Residents	2008 Ford E150 Van	2009	\$40,058	\$10,014	\$10,014	\$	4 Yrs	\$35,050	76
77										77
78										78
79										79
80	TOTALS			\$40,058	\$10,014	\$10,014	\$		\$35,050	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)	\$821,705	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$43,990	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$43,990	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)	\$475,827	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

**

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: \$ _____ Description: _____

(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

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	\$

* 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	\$	1,909	\$ 105,564	\$	1,909	\$ 105,564	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		144	8,016		144	8,016	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,208	109,867		2,208	109,867	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	4,261	\$ 223,447	\$	4,261	\$ 223,447	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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 47,562	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	724,274		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	618		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 772,454	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,000		13
14	Buildings, at Historical Cost	40,111		14
15	Leasehold Improvements, at Historical Cost	65,793		15
16	Equipment, at Historical Cost	355,764		16
17	Accumulated Depreciation (book methods)	(350,365)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Advances to Related Entities</u>	19,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 134,303	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 906,757	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 110,565	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	180,000		29
30	Accrued Salaries Payable	29,900		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,940		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Advances from Affiliates</u>	33,000		36
37	<u>Other Accrued Expenses</u>	85,468		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 458,873	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,706		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Advances from Owners</u>	312,488		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 324,194	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 783,067	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 123,690	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 906,757	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 155,606	1
2	Restatements (describe):		2
3	Correction to Census Tax Assessment Accrual	(79,075)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 76,531	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	227,159	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	(180,000)	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)	\$ 47,159	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)	\$ 123,690	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St. Elmo

0045583

Report Period Beginning: 01/01/12

Ending: 12/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,727,054	1
2	Discounts and Allowances for all Levels	(425,743)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,301,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	392,746	6
7	Oxygen	28,897	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 421,643	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	5,539	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,674	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,262	19
20	Radiology and X-Ray		20
21	Other Medical Services	26,650	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,125	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,839	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,839	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,102	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,102	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,886,020	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	512,772	31
32	Health Care	1,213,030	32
33	General Administration	552,089	33
	B. Capital Expense		
34	Ownership	158,844	34
	C. Ancillary Expense		
35	Special Cost Centers	97,567	35
36	Provider Participation Fee	124,474	36
	D. Other Expenses (specify):		
37	<u>Contributions</u>	85	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,658,861	40
41	Income before Income Taxes (line 30 minus line 40)**	227,159	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 227,159	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 26 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	2,040	2,088	\$ 59,598	\$ 28.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,289	9,423	183,186	19.44	3
4	Licensed Practical Nurses	11,888	12,678	213,973	16.88	4
5	CNAs & Orderlies	41,179	41,531	404,416	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,363	1,506	15,864	10.53	9
10	Activity Assistants	1,876	2,097	18,254	8.70	10
11	Social Service Workers	3,548	3,871	37,734	9.75	11
12	Dietician					12
13	Food Service Supervisor	1,300	1,464	18,908	12.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,174	10,842	94,387	8.71	15
16	Dishwashers					16
17	Maintenance Workers	2,004	2,136	24,812	11.62	17
18	Housekeepers	6,669	7,718	67,722	8.77	18
19	Laundry	3,639	3,148	33,290	10.57	19
20	Administrator	2,056	2,089	76,349	36.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,439	1,501	13,606	9.06	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)	98,464	102,092	\$ 1,262,099 *	\$ 12.36	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	99	\$ 5,697	1-3	35
36	Medical Director	72	9,600	9-3	36
37	Medical Records Consultant	80	1,994	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	2,990	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,269	11-3	44
45	Social Service Consultant	47	2,269	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	465	\$ 24,819		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Charles Hutson	Administrator		\$ 76,349
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,349
B. Administrative - Other			
Description			Amount
Management Fees - Rincker Healthcare			\$ 144,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 144,000
C. Professional Services			
Vendor/Payee	Type		Amount
Kemper CPA Group LLP			\$ 16,280
James D. Stout			50
Duane Morris LLP			743
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 17,073
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 40,172
Unemployment Compensation Insurance			24,119
FICA Taxes			100,985
Employee Health Insurance			29,839
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 195,115
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			562
Health Care Worker Background Check (Indicate # of checks performed 7)			252
Patient Background Checks			
Advertising			5,909
Dues & Subscriptions			4,593
License Fees			4,454
Less: Public Relations Expense		(	)
Non-allowable advertising			(5,909)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,861
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Program Transportation - Gas/oil, etc.			4,777
Entertainment & Meals			800
Administrative Travel			916
Seminar Expense			
Entertainment Expense			(1,716)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 4,777

*** 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

Facility Name & ID Number <u>Friendship Manor of St. Elmo</u>	STATE OF ILLINOIS # <u>0045583</u>	Report Period Beginning: <u>01/01/12</u>	Ending: <u>12/31/12</u>
XX. GENERAL INFORMATION:			
(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. _____ (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____ (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____ (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>n/a</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>0</u> Line <u>N/A</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____ (9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> 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. \$ <u>124,474</u> 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? <u>No</u> If YES, attach an explanation of the allocation.	(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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>0</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>0</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients? <u>100%</u> d. Have vehicle usage logs been maintained? <u>Yes</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u> (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? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees		

SEE ACCOUNTANTS' COMPILATION REPORT

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There are no training fees because Friendship Manor only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

Line Description	Amount	Line Ref
Administrative	\$ 45,685	17
Professional Services	1,601	19
Clerical & General Office Expenses	60,485	21
Employee Benefits & Payroll Taxes	7,733	22
Travel and Seminar	704	24
Insurance - Prop.Liab.Malpractice	324	26
Interest	4,476	32
Rent - Equipment & Vehicles	-	35
Contributions	135	43
Administrative	121,143	17
Depreciation	8,625	30
Interest	3,986	32
Rent - Facility Grounds	12,611	34
Grand Total of allocated costs	\$ 130,781	

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 19, Reconciliation of taxable income to book net income

Book Net Income	\$ 227,159
Rounding Variance	1
Difference book vs. tax depreciation	28,119
Disallowed Meals & Entertainment	214
Accrual to cash conversion	<u>(71,127)</u>
Taxable Income	<u><u>\$ 184,366</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes.

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	\$ 7,402.00	\$ 7,402.00	\$ 8,974.00	\$ 43,284.00	\$ 15,970.00
West Grove	4,626.00	4,626.00	21,209.00	27,052.00	9,981.00
Lawrence Comm. Healthcare Center	13,570.00	13,570.00	16,451.00	79,353.00	139,060.00
Rincker Residential	7,402.00	7,402.00	8,974.00	43,284.00	15,970.00
	<u>33,000.00</u>	<u>33,000.00</u>	<u>55,608.00</u>	<u>192,973.00</u>	<u>180,981.00</u>
Salaries reported on this cost report	<u>7,402.00</u>	<u>7,402.00</u>	<u>8,974.00</u>	<u>43,284.00</u>	<u>15,970.00</u>
Salaries reported by other homes	<u>\$ 25,598.00</u>	<u>\$ 25,598.00</u>	<u>\$ 46,634.00</u>	<u>\$ 149,689.00</u>	<u>\$ 165,011.00</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment	Vehicles	Total
Schedule XV Balance Sheet	<u>\$ 4,000</u>	<u>\$ 105,904</u>	<u>\$ 315,706</u>	<u>\$ 40,058</u>	<u>\$ 465,668</u>
Schedule XI Ownership Costs	<u>9,000</u>	<u>456,941</u>	<u>315,706</u>	<u>40,058</u>	<u>821,705</u>
Difference	<u><u>\$ (5,000)</u></u>	<u><u>\$ (351,037)</u></u>	<u><u>\$ -</u></u>	<u><u>\$ -</u></u>	<u><u>\$ (356,037)</u></u>

On January 1, 2002, Friendship Manor of St. Elmo was incorporated. The real estate, building, and building improvements were not included. The facility is rented from a related party, and the appropriate adjustments have been made on the cost report.

SEE ACCOUNTANTS' COMPILATION REPORT.

Friendship Manor of St. Elmo - Detail for Schedule V, Line 24 - Travel Costs

Account Number	Description	Amount
9169	Gas - Facility Vehicle	\$ 2,942
9169	Employee Mileage Reimbursements - Resident Transport/Errands	1,502
9170	Travel/Meals - Seminars	916
9170	Business Meals/Outings	429
		<u>5,789</u>
	Allocation of Related Party (Rincker Healthcare Inc.) Gas - Owner Costs	333
	Allocation of Related Party (Rincker Healthcare Inc.) Business Meals/Outings	371
	Adjustments - Meals/Entertainment	<u>(1,716)</u>
	Total Schedule V, Line 24 Travel Expense	<u>\$ 4,777</u>

SEE ACCOUNTANTS' COMPILATION REPORT.