

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0045187</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Farmington Country Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>701 South Main St</u> <u>Farmington</u> <u>61531</u>																									
Number City Zip Code																									
County: <u>Fulton</u>																									
Telephone Number: <u>(309) 245-2407</u> Fax # <u>(309) 245-2420</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	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												
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	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																								
Date of Initial License for Current Owners: <u>12/01/1995</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></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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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Robert Conner</u> Telephone Number: <u>(610) 832-2059</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Farmington Country Manor

0045187 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	92	Skilled (SNF)	92	33,672
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	92	TOTALS	92	33,672

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	10,987	6,729	7,583	25,299	8
9 SNF/PED					9
10 ICF					10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	10,987	6,729	7,583	25,299	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.13%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) Outpatient Therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location? Date started 12/01/1995

J. Was the facility purchased or leased after January 1, 1978? YES X Date 12/01/1995 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 92 and days of care provided 1,852

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	231,818	22,278	13,122	267,218		267,218		267,218			1
2	Food Purchase		182,973		182,973		182,973		182,973			2
3	Housekeeping	139,939	17,155		157,094		157,094		157,094			3
4	Laundry	80,645	24,273		104,918		104,918		104,918			4
5	Heat and Other Utilities			108,951	108,951		108,951		108,951			5
6	Maintenance	43,833	79,379	21,146	144,358		144,358	(28,955)	115,403			6
7	Other (specify):*											7
8	TOTAL General Services	496,235	326,058	143,219	965,512		965,512	(28,955)	936,557			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,848,613	179,778	16,293	2,044,684		2,044,684	(1,100)	2,043,584			10
10a	Therapy											10a
11	Activities	70,080	6,660		76,740		76,740		76,740			11
12	Social Services	44,560			44,560		44,560		44,560			12
13	CNA Training											13
14	Program Transportation			4,800	4,800		4,800		4,800			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,963,253	186,438	33,093	2,182,784		2,182,784	(1,100)	2,181,684			16
	C. General Administration											
17	Administrative	125,781		495,724	621,505		621,505	(245,384)	376,121			17
18	Directors Fees											18
19	Professional Services			59,496	59,496		59,496	17,968	77,464			19
20	Dues, Fees, Subscriptions & Promotions			9,733	9,733		9,733	(1,742)	7,991			20
21	Clerical & General Office Expenses	266,675	10,765	26,435	303,875		303,875	41,180	345,055			21
22	Employee Benefits & Payroll Taxes			470,532	470,532		470,532	37,438	507,970			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,454	1,454		1,454	(294)	1,160			24
25	Other Admin. Staff Transportation			2,061	2,061		2,061	(1,795)	266			25
26	Insurance-Prop.Liab.Malpractice			163,585	163,585		163,585		163,585			26
27	Other (specify):*											27
28	TOTAL General Administration	392,456	10,765	1,229,020	1,632,241		1,632,241	(152,629)	1,479,612			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,851,944	523,261	1,405,332	4,780,537		4,780,537	(182,684)	4,597,853			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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							57,943	57,943			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							347,899	347,899			32
33	Real Estate Taxes			71,223	71,223		71,223		71,223			33
34	Rent-Facility & Grounds			343,408	343,408		343,408	(335,745)	7,663			34
35	Rent-Equipment & Vehicles			39,276	39,276		39,276		39,276			35
36	Other (specify):* Mtg Insurance							11,883	11,883			36
37	TOTAL Ownership			453,907	453,907		453,907	81,980	535,887			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,012	365,944	526,956		526,956		526,956			39
40	Barber and Beauty Shops			412	412		412		412			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,404	191,404		191,404		191,404			42
43	Other (specify):* Disallowed Costs			331,557	331,557		331,557	(331,557)				43
44	TOTAL Special Cost Centers		161,012	889,317	1,050,329		1,050,329	(331,557)	718,772			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,851,944	684,273	2,748,556	6,284,773		6,284,773	(432,261)	5,852,512			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,521)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,812	30		9
10	Interest and Other Investment Income	(16)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,742)	20		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	(4,008)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,791)	43		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	(392,252)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (395,518)		\$	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)	(36,743)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,743)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (432,261)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Out of State Travel	\$ (294)	24	1
2	Disallow Laboratory Expense	(47,410)	43	2
3	Disallow Xray Expense	(1,092)	43	3
4	Offset Misc income against expense-BD Recoveries	(263,743)	43	4
5	Offset Misc income against expense-WC Refund	(5,818)	22	5
6	Offset Misc income against expense	(1,508)	21	6
7	Disallow Marketing Director wages	(41,371)	21	7
8	Disallow Marketing Director Travel Expense	(2,061)	25	8
9	Capitalized Repairs	(28,955)	6	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
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23				23
24				24
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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	(392,252)		49

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 Corportation	100	Oak Trace	Alabama	Midwest Health	Farmington	Real Estate entity
		Terrace Oaks	Alabama	of Farmington		
		Colonial Haven	Alabama			
		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.

X YES

NO

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

1		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	Administrative	\$ 495,724	American Health Corportation	100.00%	\$ 250,340	\$ (245,384)	1
2	V	19	Professional Services		American Health Corportation	100.00%	21,976	21,976	2
3	V	21	Clerical & Gen Office		American Health Corportation	100.00%	84,059	84,059	3
4	V	22	Emp Benefits & P/R Taxes		American Health Corportation	100.00%	42,422	42,422	4
5	V	32	Amortized Loan Costs		American Health Corportation	100.00%	52,521	52,521	5
6	V	34	Rent - Facility		American Health Corportation	100.00%	7,663	7,663	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 495,724			\$ 458,981	\$ * (36,743)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ 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)	
15	V	10	Nursing and Medical Records	\$ 8,440	American Health Corpotation	100.00%	\$ 7,340	\$ (1,100)	15
16	V	22	Employee Benefits & PR Taxes		American Health Corpotation	100.00%	834	834	16
17	V	25	Other Admin Staff Transport.		American Health Corpotation	100.00%	266	266	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 8,440			\$ 8,440	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ 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)	
15	V	30	Depreciation	\$	Midwest Health of Farmington	0.00%	\$ 36,131	\$ 36,131	15
16	V	32	Interest Expense	4	Midwest Health of Farmington	0.00%	295,398	295,394	16
17	V	34	Rent	343,408	Midwest Health of Farmington	0.00%		(343,408)	17
18	V	36	Mortgage Insurance		Midwest Health of Farmington	0.00%	11,883	11,883	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 343,412			\$ 343,412	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Chairman	Administrative	30.10	524,931	4	10.00	Mgmt Fee	\$ 115,455	L17, C7	1
2	Gary Stein	President & CEO	Administrative	18.00	310,863	6.67	16.66	Mgmt Fee	68,372	L17, C7	2
3	Jodi Stein	Admin Asst	Administrative	18.00	61,478	0	0.00	Mgmt Fee	13,522	L17, C7	3
4	Eric Stein	Executive VP	Administrative	11.00	84,651	6.67	16.66	Mgmt Fee	18,619	L17, C7	4
5	Michelle Stein	Shareholder	Administrative	11.00		0	0.00	Mgmt Fee	0	L17, C7	5
6	Lauren Gadol	Shareholder	Administrative	11.00		0	0.00	Mgmt Fee	0	L17, C7	6
7	Bob Conner	CFO	Administrative	0.90	156,277	6.67	16.66	Mgmt Fee	34,372	L17, C7	7
8											8
9											9
10											10
11	Note: All owner/relative wages are allocated from American Health Corporation. See Attached Schedule 7A.										11
12											12
13								TOTAL	\$ 250,340		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization American Health Corporation
Street Address 200 Barr Harbor Drive, Suite 400
City / State / Zip Code West Conshohocken, PA 19428
Phone Number (610) 832-2059
Fax Number (610) 834-2937

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Administrative	Resident Days	140,324	6	\$ 1,388,540	\$ 1,388,540	25,299	\$ 250,340	1
2	19	Professional Services	Resident Days	140,324	6	121,894		25,299	21,976	2
3	21	Clerical & Gen Office	Resident Days	140,324	6	466,249	308,620	25,299	84,059	3
4	22	Emp Benefits & P/R Taxes	Resident Days	140,324	6	235,299		25,299	42,422	4
5	32	Amortized Loan Costs	Resident Days	140,324	6	291,315		25,299	52,521	5
6	34	Rent - Facility	Resident Days	140,324	6	42,505		25,299	7,663	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					\$ 2,545,802	\$ 1,697,160		\$ 458,981	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization American Health Corporation
Street Address 200 Barr Harbor Drive, Suite 400
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Phone Number (610) 832-2059
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1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	Nursing and Medical Records	Direct Cost	5	\$ 146,808	\$ 146,808	7,340	\$ 7,340	1
2	22	Employee Benefits & PR Taxes	Direct Cost	5	16,679		834	834	2
3	25	Other Admin Staff Transport.	Direct Cost	5	5,319		266	266	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				\$ 168,806	\$ 146,808		\$ 8,440	25

SEE ACCOUNTANTS' PREPARATION 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 Mortgage		X	Facility	\$35,988.00	9/30/20	\$ 4,776,765	\$ 4,736,044	9/30/50	2.7800	\$ 282,065	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$35,988.00		\$ 4,776,765	\$ 4,736,044			\$ 282,065	9	
	B. Non-Facility Related*												
10								Amortization of Loan Costs			13,333	10	
11								Interest Income offset			(20)	11	
12								Amortized Loan Costs-Home Office			52,521	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 65,834	14	
15	TOTALS (line 9+line14)						\$ 4,776,765	\$ 4,736,044			\$ 347,899	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,883 Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	73,226	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.)		2019		\$	70,463	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,763)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	73,986	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.				\$	71,223	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	67,965	8	FOR BHF USE ONLY	
		2016	67,479	9		
		2017	68,653	10		
		2018	69,738	11		
		2019	70,463	12		
Accrual based on prior year tax bill.				13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 05-04-12-300-013	LAND & BUILDING	\$ 69,431.24	\$ 69,431.24
2. 05-04-12-300-002	LAND & BUILDING	\$ 782.82	\$ 782.82
3. 05-04-12-300-017	LAND & BUILDING	\$ 26.12	\$ 26.12
4. 05-04-12-300-016	LAND & BUILDING	\$ 222.44	\$ 222.44
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 70,462.62	\$ 70,462.62

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 BRICKFrame STEELNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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		31621	\$ 34,115	1
2					2
3	TOTALS			\$ 34,115	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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		\$ 2,264,583		30		\$	\$ 2,264,583	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1987 Additions		1987		2,769		25			2,769	9
10	1988 Additions		1988		50,953		VARIOUS			50,953	10
11	1989 Additions		1989		36,365		VARIOUS			36,365	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			17,568	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		39	723	723	12,654	20
21	Paving Parking Lot		2003		41,839		15			41,839	21
22	Parking Lot		2006		4,890		39	125	125	1,776	22
23	Paving /Blacktopping		2007		4,250		39	109	109	1,503	23
24	Roof		2008		41,366		15	2,758	2,758	34,484	24
25											25
26	Venting		2009		22,548		39	578	578	6,575	26
27	Blinds And Window Treatments		2009		5,132		39	131	131	1,456	27
28	Dining Room Floor		2009		19,295		39	495	495	5,466	28
29	Venting Materials		2009		1,582		39	41	41	453	29
30	Leasehold Improvement		2010		1,122		7			1,122	30
31	Nurse Call Station		2010		4,600		15	306	306	3,222	31
32	Nurse Call Station		2010		21,526		15	1,436	1,436	15,077	32
33	Carpet		2010		1,927		7			1,927	33
34											34
35	Nursing Hallway - Floor Tiles		2011		1,319		39	34	34	336	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' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Outside - Seal Coating, Benches, Landscaping Rock	2012	\$ 9,754	\$	39	\$ 250	\$ 250	\$ 2,136	37
38	Outside - Concrete Installation, Fencing, Sign	2012	11,473		39	294	294	2,512	38
39	Therapy Room Flooring	2012	3,494		39	90	90	761	39
40	Architect Fees For Therapy Room Hallway	2012	1,954		39	50	50	402	40
41	Shower Room Upgrade (200-300 Wing) Gutted and installed	2012	25,250		39	647	647	5,203	41
42	flooring, tile, drywall, cabinets, tub, lighting								42
43	Architect Fees-Therapy Room Hallway	2013	1,338		39	34	34	268	43
44	Sprinkler System-200 Wing	2013	8,914		39	228	228	1,802	44
45	New Plumbing System-Piping/Shutoff Valves throughout	2013	11,203		39	287	287	2,237	45
46	New Plumbing System-Piping/Shutoff Valves throughout	2013	4,002		39	102	102	801	46
47	New Hardwood Flooring-Hallways	2013	31,128		7			31,128	47
48	New Plumbing System-Piping/Shutoff Valves throughout	2013	2,426		39	62	62	478	48
49	Therapy Rm Hallway Modifications-Install Wall/Door to Enclose	2013	14,348		7			14,348	49
50	New Exterior Signs	2013	4,590		39	118	118	900	50
51	Project 3077 Plans-Therapy Room Hallway	2013	1,277		39	33	33	249	51
52	New Wall Mural	2013	1,200		15	80	80	610	52
53	New Stone Floor Tile-Nurses Station	2013	3,366		15	225	225	1,659	53
54	Kamdean Stock Flooring-Room 204	2013	1,055		15	70	70	516	54
55	Remove Concrete and Relocate Light Pole	2013	4,400		39	113	113	833	55
56	3 lite Slider Windows for Rooms 314 & 317	2013	2,485		15	166	166	1,224	56
57	Concrete Installation-Extend Sidewalk/Front Entrance	2013	3,740		39	96	96	700	57
58	New Windows	2013	2,485		15	166	166	1,224	58
59	Shower Tile-Small Shower Room-200 Wing	2013	3,368		15	225	225	1,659	59
60	Hardwood Flooring-Room 206	2013	2,528		15	169	169	1,204	60
61	Tile and Cove Base-Room 208	2013	2,528		15	169	169	1,204	61
62	Tile and Cove Base-Room 210/212	2013	2,717		15	181	181	1,290	62
63	Tile and Cove Base-Resident Rooms	2014	10,539		15	702	702	4,563	63
64	Window Replacement - 91 new windows	2014	62,710		15	4,180	4,180	27,170	64
65	Thru Wall Air Conditioner Units	2014	6,728		15	448	448	2,912	65
66	Replace siding	2014	8,249		15	550	550	3,575	66
67	Repave parking lot	2014	70,000		15	4,667	4,667	30,335	67
68	Rewire and repair outside sign and rewire lightpole	2014	4,332		15	289	289	1,878	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,959,430	\$		\$ 21,427	\$ 21,427	\$ 2,709,888	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,959,430	\$		\$ 21,427	\$ 21,427	\$ 2,709,888	1
2	Tile and Cove Base - 6 Resident Rooms	2014	5,204		15	347	347	2,256	2
3	Install new humidifier on furnace	2014	3,350		15	223	223	1,450	3
4	Tile and Cove Base - SS Office, Bus. Office, Med Rec Office,	2015	22,406		15	1,494	1,494	8,217	4
5	Utility Closets, 2 Bathrooms & Remaining Resident Rms								5
6	Seal Parking Lot	2015	2,900		15	193	193	1,062	6
7	6 Thru-Wall Air Conditioning Units	2016	3,991		15	266	266	1,197	7
8	Woodplank Floor Tile - Activity Rm and Breakroom	2016	2,724		15	182	182	819	8
9	Draperies and Cubicle Curtains - Resident Rooms	2017	33,821		15	2,255	2,255	7,892	9
10	Install On Demand Water Heater	2017	3,835		15	256	256	896	10
11	Front Office-New Carpeting, Window Treatments & Painting	2017	5,544		15	370	370	1,295	11
12	Metal Shed for Motor Storage	2017	3,391		15	226	226	791	12
13	Seal Parking Lot	2017	3,250		15	217	217	759	13
14	New Siding - Portion of Siding on Front & Back of Building	2017	8,956		15	597	597	2,090	14
15	Repair and Replace Roof on Gazebo	2017	4,800		15	320	320	1,120	15
16	Replace Doors to Generator Room and Small Garage	2017	2,550		15	170	170	595	16
17	Install 200 Amp Emergency Panel	2018	14,845		39	381	381	1,032	17
18	Asphalt Paving - Added New Paved Area	2018	22,620		15	1,508	1,508	3,770	18
19	Install Circulation Pump	2019	4,865		5	973	973	1,460	19
20	Replace Water Mixing Valve	2020	3,325		15	111	111	111	20
21	Wandering Patient Door Alarm System	2020	6,368		5	1,274	1,274	1,274	21
22	Roof Top Unit 150,000 BTU 2 Stage Heating, 5 Ton Cooling	2020	8,900		5	1,780	1,780	1,780	22
23	Walk In Freezer Condensing Unit Replacement	2020	8,093		5	1,619	1,619	1,619	23
24	Fabricate and Install Steel Railings for Wheelchair Ramp	2020	3,971		15	132	132	132	24
25	Rear Entrance Door Replacement	2020	2,519		15	84	84	84	25
26	Parking Lot-Seal Coat. Crack Fill, Striping, Handicap Signs	2020	7,944		15	265	265	265	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,149,602	\$		\$ 36,670	\$ 36,670	\$ 2,751,854	34

SEE ACCOUNTANTS' PREPARATION 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	\$1,256,606	\$	\$17,045	\$17,045	3-15 yrs	\$1,196,614	71
72	Current Year Purchases	42,162		4,228	4,228	5 yrs	4,228	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,298,768	\$	\$21,273	\$21,273		\$1,200,842	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	\$	\$	\$	5	\$45,133	76
77	Patient Care	2013 Dodge Grand Caravan	2013	47,384				5	47,384	77
78										78
79										79
80	TOTALS			\$92,517	\$	\$	\$		\$92,517	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,575,002	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$57,943	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$57,943	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,045,213	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Allocated from Management Company
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:				\$7,663			3
4	Additions							4
5								5
6								6
7	TOTAL				\$7,663			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☐ NOTerms:*

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$39,276Description: Nursing Equipment - \$27,655; Dietary Equipment - \$1,120; Admin Equipment - \$10,501
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

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

D. NUMBER OF CNAs TRAINED

		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.	
\$	

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	3,314	\$ 161,668	\$	3,314	\$ 161,668	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		468	27,763		468	27,763	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		2,726	176,513		2,726	176,513	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				160,642		160,642	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Resp Therapy Supp	39(2)					370		370	12
13	Other (specify):									13
14	TOTAL			\$	6,508	\$ 365,944	\$ 161,012	6,508	\$ 526,956	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 460,348	\$ 460,601	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27)	451,685	451,685	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,662	1,662	6
7	Other Prepaid Expenses	4,491	43,750	7
8	Accounts Receivable (owners or related parties)	4,716,438	8,803,616	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,634,624	\$ 9,761,314	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		885,019	15
16	Equipment, at Historical Cost		1,391,285	16
17	Accumulated Depreciation (book methods)		(4,045,213)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		200,978	21
22	Other Long-Term Assets (specify):		115,178	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 845,945	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,634,624	\$ 10,607,259	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 170,546	\$ 170,546	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		103,401	29
30	Accrued Salaries Payable	196,820	196,820	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,986	73,986	32
33	Accrued Interest Payable	1,252	12,224	33
34	Deferred Compensation	1,802,996	1,802,996	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Taxes	50,029	50,029	36
37	Due to Third Parties	150,059	150,059	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,445,688	\$ 2,560,061	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,632,643	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)	\$	\$ 4,632,643	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,445,688	\$ 7,192,704	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,188,936	\$ 3,414,555	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,634,624	\$ 10,607,259	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,603,777	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,603,777	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(414,841)	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)	\$ (414,841)	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)	\$ 3,188,936	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 5,055,593	1
2	Discounts and Allowances for all Levels	(246,068)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,809,525	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	567,728	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 567,728	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,801	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	63,055	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,856	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	317,807	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 317,807	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,869,932	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	965,512	31
32	Health Care	2,182,784	32
33	General Administration	1,632,241	33
	B. Capital Expense		
34	Ownership	453,907	34
	C. Ancillary Expense		
35	Special Cost Centers	858,925	35
36	Provider Participation Fee	191,404	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,284,773	40
41	Income before Income Taxes (line 30 minus line 40)**	(414,841)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (414,841)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,719,194	44
45	Private Pay - Net Inpatient Revenue	1,381,720	45
46	Medicare - Net Inpatient Revenue	710,156	46
47	Other-(specify) <u>Insurance</u>	92,764	47
48	Other-(specify) <u>VA/Hospice</u>	905,691	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,809,525	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION 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	1,892	2,123	\$ 104,598	\$ 49.27	1
2	Assistant Director of Nursing	1,767	2,076	74,858	36.06	2
3	Registered Nurses	8,539	9,506	343,334	36.12	3
4	Licensed Practical Nurses	16,868	19,563	441,342	22.56	4
5	CNAs & Orderlies	51,490	58,094	814,036	14.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	2,112	31,913	15.11	9
10	Activity Assistants	2,799	3,043	38,167	12.54	10
11	Social Service Workers	1,895	2,160	44,560	20.63	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,167	53,311	24.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,040	16,718	178,507	10.68	15
16	Dishwashers					16
17	Maintenance Workers	1,986	2,247	43,833	19.51	17
18	Housekeepers	10,198	11,514	139,939	12.15	18
19	Laundry	5,393	6,093	80,645	13.24	19
20	Administrator	1,897	2,126	125,781	59.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,641	10,015	266,675	26.63	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 C: MDS Coord	1,784	2,127	70,445	33.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,933	151,684	\$ 2,851,944 *	\$ 18.80	34

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

** See instructions.

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	\$ 13,122	L1, C3	35
36	Medical Director	96	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	7,853	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	480	\$ 32,975		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Farmington Country Manor

0045187

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	\$ 125,781	Workers' Compensation Insurance	\$ 51,405	IDPH License Fee	\$	
				Unemployment Compensation Insurance	12,699	Advertising: Employee Recruitment	119	
				FICA Taxes	199,328	Health Care Worker Background Check		
				Employee Health Insurance	197,970	(Indicate # of checks performed 9)	360	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	6,072	
				Other Employee Benefits	3,312	Misc Dues and Subscriptions	1,782	
						Misc Licenses	1,400	
TOTAL (agree to Schedule V, line 17, col. 1)				Allocated from American Health Corp	43,256			
(List each licensed administrator separately.)			\$ 125,781					

B. Administrative - Other		Amount
Description		
Management Fees-See Page 6, Eliminated on P 3, C 7		\$ 495,724
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 495,724
(Attach a copy of any management service agreement)		

C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount
Nerds On Call	Computer Services	\$ 6,547			\$	Out-of-State Travel	\$
American Healthtech	Healthcare Software	10,537					
YoloCare	Website Services	654					
Prime Care Technologies	Information Technology	18,357				In-State Travel	
eSolutions	Health Info Management	8,030					
Paychex	Payroll Service	11,213					
Johnson & Johnson	Legal Services	4,158					
						Seminar Expense	1,160
						Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)		\$ 59,496				TOTAL	\$ 1,160

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

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?
If YES, give association name and amount.

Yes
6,072 IHCA

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
5 yrs

(6)

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

\$ Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 191,404

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

Out-Patient Therapy

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
No
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% Line 14

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
N/A

(18)

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

Yes

(19)

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

Yes

SEE ACCOUNTANTS' PREPARATION REPORT