

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0045187

**Facility Name:** FARMINGTON COUNTRY MANOR

**Address:** 701 SOUTH MAIN STREET FARMINGTON 61531  
 Number City Zip Code

**County:** FULTON

**Telephone Number:** 309-245-2407 **Fax #** 309-245-2420

**HFS ID Number:** 23-2402757-002

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** \_\_\_\_\_ **Telephone Number:** ( ) \_\_\_\_\_

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>BOB CONNER</u>	
	(Title) <u>CHIEF FINANCIAL OFFICER</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

**Phone # (217) 782-1630**

Facility Name & ID Number FARMINGTON COUNTRY MANOR# 0045187 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,791</u>	<u>12,544</u>	<u>4,099</u>	<u>31,434</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>14,791</u>	<u>12,544</u>	<u>4,099</u>	<u>31,434</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.61%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? \_\_\_\_\_

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

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

YES  NO 

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

Date started 12/01/1995

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

YES  Date 12/01/1995 NO 

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

YES  NO  If YES, enter number of beds certified 92 and days of care provided 4,099Medicare Intermediary RIVERBEND GOVERNMENT BENEFITS ADMINISTRATOR

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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
	<b>A. General Services</b>										
1	Dietary	178,890	18,200	25,344	222,434		222,434	(11,923)	210,511		1
2	Food Purchase		167,733		167,733		167,733		167,733		2
3	Housekeeping	98,408	16,162		114,570		114,570		114,570		3
4	Laundry	56,958	23,678		80,636		80,636		80,636		4
5	Heat and Other Utilities			140,113	140,113		140,113		140,113		5
6	Maintenance	52,043	16,153	27,595	95,791		95,791		95,791		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>386,299</b>	<b>241,926</b>	<b>193,052</b>	<b>821,277</b>		<b>821,277</b>	<b>(11,923)</b>	<b>809,354</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,290,058	51,780	108,660	1,450,498		1,450,498		1,450,498		10
10a	Therapy		3,160	402,185	405,345		405,345		405,345		10a
11	Activities	51,914	7,574	(590)	58,898		58,898		58,898		11
12	Social Services	56,860			56,860		56,860		56,860		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,398,832</b>	<b>62,514</b>	<b>510,255</b>	<b>1,971,601</b>		<b>1,971,601</b>		<b>1,971,601</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	78,000		370,615	448,615		448,615	(116,108)	332,507		17
18	Directors Fees										18
19	Professional Services			3,300	3,300		3,300	17,973	21,273		19
20	Dues, Fees, Subscriptions & Promotions			23,443	23,443		23,443	(11,919)	11,524		20
21	Clerical & General Office Expenses	152,613	8,060	98,193	258,866		258,866	(39,260)	219,606		21
22	Employee Benefits & Payroll Taxes			589,191	589,191		589,191	38,066	627,257		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,453	5,453		5,453	2,369	7,822		24
25	Other Admin. Staff Transportation			13,461	13,461		13,461		13,461		25
26	Insurance-Prop.Liab.Malpractice			102,189	102,189		102,189		102,189		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>230,613</b>	<b>8,060</b>	<b>1,205,845</b>	<b>1,444,518</b>		<b>1,444,518</b>	<b>(108,879)</b>	<b>1,335,639</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,015,744</b>	<b>312,500</b>	<b>1,909,152</b>	<b>4,237,396</b>		<b>4,237,396</b>	<b>(120,802)</b>	<b>4,116,594</b>		<b>29</b>

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

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR #0045187 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	<b>D. Ownership</b>										
30	Depreciation			142,589	142,589		142,589	436	143,025		30
31	Amortization of Pre-Op. & Org.			6,608	6,608		6,608		6,608		31
32	Interest			186,239	186,239		186,239	(4,243)	181,996		32
33	Real Estate Taxes			53,004	53,004		53,004		53,004		33
34	Rent-Facility & Grounds							6,651	6,651		34
35	Rent-Equipment & Vehicles							14,643	14,643		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			388,440	388,440		388,440	17,487	405,927		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		8,034	165,777	173,811		173,811		173,811		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			50,370	50,370		50,370		50,370		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		8,034	216,147	224,181		224,181		224,181		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,015,744	320,534	2,513,739	4,850,017		4,850,017	(103,315)	4,746,702		45

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR

# 0045187

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(4,243)	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,718)	21		24
25	Fund Raising, Advertising and Promotional	(11,919)	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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (69,880)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(33,435)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (33,435)		36
(sum of SUBTOTALS				
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (103,315)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

FARMINGTON COUNTRY MANOR

ID# 0045187

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number FARMINGTON COUNTRY MANOR# 0045187

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	(11,923)	0	0	0	0	0	0	0	0	0	(11,923)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</b>	0	(11,923)	0	0	0	0	0	0	0	0	0	(11,923)	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	(116,108)	0	0	0	0	0	0	0	0	0	(116,108)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,973	0	0	0	0	0	0	0	0	0	17,973	19
20	Fees, Subscriptions & Promotions	(11,919)	0	0	0	0	0	0	0	0	0	0	(11,919)	20
21	Clerical & General Office Expenses	(53,718)	14,458	0	0	0	0	0	0	0	0	0	(39,260)	21
22	Employee Benefits & Payroll Taxes	0	38,066	0	0	0	0	0	0	0	0	0	38,066	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,369	0	0	0	0	0	0	0	0	0	2,369	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	<b>TOTAL General Administration</b>	(65,637)	(43,242)	0	0	0	0	0	0	0	0	0	(108,879)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(65,637)	(55,165)	0	0	0	0	0	0	0	0	0	(120,802)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FARMINGTON COUNTRY MANOR

# 0045187

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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	436	0	0	0	0	0	0	0	0	0	436	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,243)	0	0	0	0	0	0	0	0	0	0	(4,243)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,651	0	0	0	0	0	0	0	0	0	6,651	34
35	Rent-Equipment & Vehicles	0	14,643	0	0	0	0	0	0	0	0	0	14,643	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,243)</b>	<b>21,730</b>	<b>0</b>	<b>17,487</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(69,880)</b>	<b>(33,435)</b>	<b>0</b>	<b>(103,315)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	\$ 11,923	AMERICAN HEALTH CORPORATION	100.00%	\$ (11,923)	1
2	V	17	ADMINISTRATION	370,615	AMERICAN HEALTH CORPORATION	100.00%	254,507	2
3	V	19	PROFESSIONAL SERVICES		AMERICAN HEALTH CORPORATION	100.00%	17,973	3
4	V	21	CLERICAL & GEN OFFICE EXP		AMERICAN HEALTH CORPORATION	100.00%	14,458	4
5	V	22	EMP. BENEFITS & PAYROLL TAX		AMERICAN HEALTH CORPORATION	100.00%	38,066	5
6	V	24	TRAVEL SEMINAR		AMERICAN HEALTH CORPORATION	100.00%	2,369	6
7	V	30	DEPRECIATION		AMERICAN HEALTH CORPORATION	100.00%	436	7
8	V	34	RENT-FACILITY & GROUNDS		AMERICAN HEALTH CORPORATION	100.00%	6,651	8
9	V	35	RENT-FACILITY & VEHICLES		AMERICAN HEALTH CORPORATION	100.00%	14,643	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 382,538			\$ 349,103	\$ * (33,435)	14

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	NOT APPLICABLE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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.

Facility Name & ID Number FARMINGTON COUNTRY MANOR

# 0045187

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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

Name of Related Organization American Health Corporation  
 Street Address 525 Plymouth Road, Suite 310  
 City / State / Zip Code Plymouth Meeting, PA 19462  
 Phone Number ( 610-832-2059  
 Fax Number ( 610-834-2937

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administrative	Patient Days	134,494	5	\$ 1,054,345	\$ 31,468	\$ 246,689	1
2	19	Professional Services	Patient Days	134,494	5	76,815	31,468	17,973	2
3	21	Clerical & Gen. Office Exp	Patient Days	134,494	5	61,793	31,468	14,458	3
4	22	Emp. Benefits & Payroll Taxes	Patient Days	134,494	5	156,618	31,468	36,644	4
5	24	Travel & Seminar	Patient Days	134,494	5		31,468	0	5
6	34	Rent- Facility & Grounds	Patient Days	134,494	5	28,425	31,468	6,651	6
7	35	Rent-Equipment & Vehicles	Patient Days	134,494	5	62,586	31,468	14,643	7
8	17	Administrative	Hours	2,080	5	153,770	106	7,819	8
9	19	Professional Services	Hours	2,080	5		106	0	9
10	21	Clerical & Gen. Office Exp	Hours	2,080	5		106	0	10
11	22	Emp. Benefits & Payroll Taxes	Hours	2,080	5	27,950	106	1,421	11
12	24	Travel & Seminar	Hours	2,080	5	23,288	106	1,184	12
13	34	Rent-Facility & Grounds	Hours	2,080	5		106	0	13
14	35	Rent-Equipment & Vehicles	Hours	2,080	5		106	0	14
15	30	Depreciation	Patient Days	134,494	5	1,862	31,468	436	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,647,452	\$	\$ 347,918	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Cap Mark		X	Mortgage			\$ 3,017,500	\$ 2,736,670	03/01/29	6.1500	\$ 181,996	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 3,017,500	\$ 2,736,670			\$ 181,996	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,017,500	\$ 2,736,670			\$ 181,996	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.)

\*\* 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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$	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.)		\$ <b>53,004</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>53,004</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>53,004</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>41,937</u>	<u>8</u>
	2003	<u>45,138</u>	<u>9</u>
	2004	<u>45,048</u>	<u>10</u>
	2005	<u>52,802</u>	<u>11</u>
	2006	<u>53,004</u>	<u>12</u>
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME FARMINGTON COUNTRY MANOR COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0045187

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>05-04-12-300-013</u>	<u>Building</u>	\$ <u>52,171.86</u>	\$ <u>52,171.86</u>
2. <u>05-04-12-300-016</u>	<u>Building</u>	\$ <u>167.32</u>	\$ <u>167.32</u>
3. <u>05-04-12-300-017</u>	<u>Building</u>	\$ <u>19.18</u>	\$ <u>19.18</u>
4. <u>05-04-12-300-002</u>	<u>Building</u>	\$ <u>645.28</u>	\$ <u>645.28</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>53,003.64</u>	\$ <u>53,003.64</u>

**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        NO

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR

# 0045187 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 34,115	1
2					2
3	TOTALS			\$ 34,115	3

Facility Name & ID Number **FARMINGTON COUNTRY MANOR**

# **0045187**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1986		\$ 2,264,583	\$ 75,486	30	\$ 75,486	\$	\$ 1,624,039	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10	1987 Additions		1987		6,697	110	Various	110		6,208	10
11	1988 Additions		1988		62,921	1,674	Various	1,674		45,856	11
12	1989 Additions		1989		44,052	1,584	Various	1,584		40,957	12
13	1990 Additions		1990		12,297		Various			12,297	13
14	1991 Additions		1991		47,682		Various			47,682	14
15	1992 Additions		1992		9,257	162	Various	162		9,257	15
16	1993 Additions		1993		18,389	191	Various	191		18,292	16
17	1994 Additions		1994		19,990	1,128	Various	1,128		18,305	17
18	1995 Additions		1995		2,386	116	Various	116		2,095	18
19	Carpet		2001		300		3			300	19
20	Furniture & Fixtures		2001		1,900	170	7	170		1,778	20
21	Roof		2003		28,208	723	32	723		3,255	21
22	Garage										22
23	Paving Parking Lot		2003		41,839	2,792	15	2,792		17,137	23
24	Furniture & Fixtures		2004		45,979	4,599	10	4,599		57,474	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

\*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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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 <b>Install new tiles in kitchen</b>	<b>2005</b>	\$ <b>18,829</b>	\$ <b>2,691</b>	<b>5</b>	\$ <b>2,691</b>	\$	\$ <b>6,778</b>	37
38								38
39 <b>Cabinets</b>	<b>2006</b>	<b>2,458</b>	<b>351</b>	<b>7</b>	<b>351</b>		<b>527</b>	39
40 <b>Parking Lot</b>	<b>2006</b>	<b>4,890</b>	<b>125</b>	<b>39</b>	<b>125</b>		<b>151</b>	40
41 <b>Leasehold Improvements</b>	<b>2007</b>	<b>4,250</b>	<b>86</b>	<b>39</b>	<b>86</b>		<b>86</b>	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 <b>TOTAL (lines 4 thru 69)</b>		\$ <b>2,636,907</b>	\$ <b>91,988</b>		\$ <b>91,988</b>	\$	\$ <b>1,912,474</b>	70

\*\*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: 01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 518,073	\$ 38,898	\$ 38,898	\$	Various	\$ 340,006	71
72	Current Year Purchases	36,756	5,253	5,253			5,253	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 554,829	\$ 44,151	\$ 44,151	\$		\$ 345,259	75

D. Vehicle Depreciation (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	Van		2007	\$ 45,133	\$ 6,450	\$ 6,450	\$	7	\$ 6,450	76
77										77
78										78
79										79
80	TOTALS			\$ 45,133	\$ 6,450	\$ 6,450	\$		\$ 6,450	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)	\$ 3,270,984	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 142,589	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 142,589	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,264,183	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.

Facility Name & ID Number FARMINGTON COUNTRY MANOR

# 0045187

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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.

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

	Service	Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist		3452.20 hrs	\$ 174,308		\$	\$		3,452	\$ 174,308	1	
2	Licensed Speech and Language Development Therapist		754.30 hrs	36,269					754	36,269	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist		3762.50 hrs	191,607					3,763	191,607	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	
11	Academic Education		hrs								11	
12	Exceptional Care Program										12	
13	Other (specify):										13	
14	<b>TOTAL</b>			\$ 402,184		\$	\$		7,969	\$ 402,184	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.

Facility Name & ID Number FARMINGTON COUNTRY MANOR# 0045187Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 64,960	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	390,442		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,613		7
8	Accounts Receivable (owners or related parties)	1,780,220		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,246,235	\$	10
	<b>B. Long-Term Assets</b>			
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	250,849		15
16	Equipment, at Historical Cost	684,713		16
17	Accumulated Depreciation (book methods)	(2,252,520)		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):	400,859		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,382,599	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,628,834	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 195,237	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,025		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to/From other divisions</u>	183,210		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 543,680	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,736,670		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,736,670	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,280,350	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 348,484	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,628,834	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>385,090</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>385,090</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(36,606)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(36,606)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>348,484</b>	<b>24</b> *

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR# 0045187Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,494,746	1
2	Discounts and Allowances for all Levels	(592,282)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,902,464	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	681,853	6
7	Oxygen	25,031	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 706,884	8
<b>C. Other Operating Revenue</b>			
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	159,235	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 159,235	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	44,828	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 44,828	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,813,411	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	821,277	31
32	Health Care	1,971,601	32
33	General Administration	1,444,518	33
<b>B. Capital Expense</b>			
34	Ownership	388,440	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	224,181	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,850,017	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(36,606)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (36,606)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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.

Facility Name & ID Number **FARMINGTON COUNTRY MANOR**

# **0045187**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**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		4,168	\$ 112,457	\$ 26.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses		2,665	54,777	20.55	3
4	Licensed Practical Nurses		24,682	437,332	17.72	4
5	CNAs & Orderlies		55,254	530,626	9.60	5
6	CNA Trainees		2,104	48,989	23.28	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides		4,004	50,224	12.54	8
9	Activity Director		2,088	21,492	10.29	9
10	Activity Assistants		2,576	30,422	11.81	10
11	Social Service Workers		4,094	56,859	13.89	11
12	Dietician					12
13	Food Service Supervisor		2,064	32,554	15.77	13
14	Head Cook					14
15	Cook Helpers/Assistants		17,809	146,335	8.22	15
16	Dishwashers					16
17	Maintenance Workers		3,835	52,042	13.57	17
18	Housekeepers		11,626	98,408	8.46	18
19	Laundry		6,423	56,959	8.87	19
20	Administrator		2,080	78,000	37.50	20
21	Assistant Administrator					21
22	Other Administrative		8,237	152,613	18.53	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction		1,772	34,738	19.60	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: <u>Central Supply</u>		2,088	20,914	10.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		157,569	\$ 2,015,741 *	\$ 12.79	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)		\$		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





