



Facility Name & ID Number Friendship Manor of St Elmo

# 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>18</u>	Intermediate (ICF)	<u>18</u>	<u>6,570</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,900</u>	7

B. Census-For the entire report period.

	1 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>10,887</u>	<u>4,073</u>	<u>3,179</u>	<u>18,139</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,887</u>	<u>4,073</u>	<u>3,179</u>	<u>18,139</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.83%

D. How many bed-hold days during this year were paid by the Department? 223 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/99

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/26/99 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 42 and days of care provided 3,179

Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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	93,363	9,347	5,585	108,295		108,295		108,295		1
2	Food Purchase		92,912		92,912		92,912	(5,561)	87,351		2
3	Housekeeping	60,433	18,223		78,656		78,656		78,656		3
4	Laundry	16,371	9,988	73	26,432		26,432		26,432		4
5	Heat and Other Utilities			47,294	47,294		47,294		47,294		5
6	Maintenance	21,998	6,164	45,419	73,581		73,581		73,581		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	192,165	136,634	98,371	427,170		427,170	(5,561)	421,609		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	720,123	32,673	2,035	754,831		754,831		754,831		10
10a	Therapy		492	168,322	168,814		168,814		168,814		10a
11	Activities	25,493	358	2,525	28,376		28,376		28,376		11
12	Social Services	24,774		2,525	27,299		27,299		27,299		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	770,390	33,523	185,007	988,920		988,920		988,920		16
	<b>C. General Administration</b>										
17	Administrative	65,270		144,000	209,270	(64,602)	144,668	(44,668)	100,000		17
18	Directors Fees										18
19	Professional Services			16,515	16,515	1,233	17,748		17,748		19
20	Dues, Fees, Subscriptions & Promotions			13,873	13,873		13,873	(3,479)	10,394		20
21	Clerical & General Office Expenses	7,741		110,819	118,560	54,523	173,083	(90,589)	82,494		21
22	Employee Benefits & Payroll Taxes			175,740	175,740	3,222	178,962		178,962		22
23	Inservice Training & Education			1,065	1,065		1,065		1,065		23
24	Travel and Seminar			6,790	6,790	1,745	8,535	(2,236)	6,299		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,435	51,435	271	51,706		51,706		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	73,011		520,237	593,248	(3,608)	589,640	(140,972)	448,668		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,035,566	170,157	803,615	2,009,338	(3,608)	2,005,730	(146,533)	1,859,197		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			23,866	23,866	8,705	32,571		32,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,393	1,393	23,248	24,641	(2,365)	22,276			32
33	Real Estate Taxes			20,290	20,290		20,290		20,290			33
34	Rent-Facility & Grounds			102,000	102,000	(31,165)	70,835	(70,835)				34
35	Rent-Equipment & Vehicles			78	78	2,110	2,188		2,188			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			147,627	147,627	2,898	150,525	(73,200)	77,325			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			157,697	157,697		157,697	(684)	157,013			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* <b>Contributions</b>			160	160	710	870	(870)				43
44	<b>TOTAL Special Cost Centers</b>			190,707	190,707	710	191,417	(1,554)	189,863			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,035,566	170,157	1,141,949	2,347,672		2,347,672	(221,287)	2,126,385			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo

# 0045583

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	(5,458)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(103)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(768)	24		15
16	Personal Expenses (Including Transportation)	(684)	39		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,175)	24		19
20	Contributions	(870)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,349)	21		24
25	Fund Raising, Advertising and Promotional	(3,479)	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	(533)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (105,784)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(115,503)	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (115,503)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (221,287)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0045583  
 Report Period Beginning: 01/01/07  
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Transportation Reimbursement	\$ (293)	24
2	Miscellaneous Income	(240)	21
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	<b>Total</b>	(533)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Friendship Manor of St Elmo

# 0045583

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,561)	0	0	0	0	0	0	0	0	0	0	(5,561)	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>	<b>(5,561)</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>(5,561)</b>	<b>8</b>
	<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>	<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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(44,668)	0	0	0	0	0	0	0	0	0	(44,668)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,479)	0	0	0	0	0	0	0	0	0	0	(3,479)	20
21	Clerical & General Office Expenses	(90,589)	0	0	0	0	0	0	0	0	0	0	(90,589)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,236)	0	0	0	0	0	0	0	0	0	0	(2,236)	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>	<b>(96,304)</b>	<b>(44,668)</b>	<b>0</b>	<b>(140,972)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(101,865)</b>	<b>(44,668)</b>	<b>0</b>	<b>(146,533)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Capital Expense	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>D. Ownership</b>												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(2,365)	0	0	0	0	0	0	0	0	0	0	(2,365) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(70,835)	0	0	0	0	0	0	0	0	0	(70,835) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(2,365)</b>	<b>(70,835)</b>	<b>0</b>	<b>(73,200) 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	(684)	0	0	0	0	0	0	0	0	0	0	(684) 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):*	(870)	0	0	0	0	0	0	0	0	0	0	(870) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,554)</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>(1,554) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(105,784)</b>	<b>(115,503)</b>	<b>0</b>	<b>(221,287) 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
See Pg 29						

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fee	\$ 144,000	Rincker Healthcare Corporation	100.00%	\$ 99,332	\$	(44,668) 1
2	V	34 Rent	102,000	William Rincker Trust		31,165		(70,835) 2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 246,000			\$ 130,497	\$ *	(115,503) 14

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

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	William J. Rincker		Administration	0.25	26,004	5	0.10	Wages	\$ 6,996	17-1	1
2	Angela West		Administration	0.25	26,004	5	0.10	Wages	6,996	17-1	2
3	Deanna Gillis		Administration	0.25	26,004			Wages	6,996	17-1	3
4	Jane Rincker	Accounting Supr.	Bookkeeping	0.25	151,687	10	0.25	Wages	40,813	21-1	4
5	William R. Gillis	President	Administration		120,055	2.5	0.06	Wages	9,795	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 71,596		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo

# 0045583 Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Attached Schedule Pg 25				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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	First Financial Bank NA		X	Refinance Purchase	\$5,420.02	2/15/07	\$ 357,666	\$ 320,506	1/15/14	7.1250	\$ 23,853	1								
2												2								
3	First Financial Bank NA		X	Purchase - Rincker Healthcare							788	3								
4				see page 25								4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$5,420.02		\$ 357,666	\$ 320,506			\$ 24,641	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>						\$ 357,666	\$ 320,506			\$ 24,641	15								

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

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

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

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

**B. Real Estate Taxes**

<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.		\$ <b>19,302</b>	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>19,796</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>494</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>19,796</b>	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>20,290</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<b>15,404</b>	8
	2003	<b>17,241</b>	9
	2004	<b>18,629</b>	10
	2005	<b>19,302</b>	11
	2006	<b>19,303</b>	12
<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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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,

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

FACILITY NAME Friendship Manor of St Elmo COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0045583

CONTACT PERSON REGARDING THIS REPORT John Knoblett, CPA

TELEPHONE (217) 351-2073 FAX #: (217) 351-3487

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

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>01-12-27-237-002</u>	<u>Land</u>	\$ <u>137.90</u>	\$ <u>137.90</u>
2. <u>01-12-27-237-003</u>	<u>Building and Land</u>	\$ <u>18,137.60</u>	\$ <u>18,137.60</u>
3. <u>01-12-27-237-004</u>	<u>Building and Land</u>	\$ <u>1,520.44</u>	\$ <u>1,520.44</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>19,795.94</u>	\$ <u>19,795.94</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 direct used for nursing home services?        YES   X   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 Friendship Manor of St Elmo

# 0045583

Report Period Beginning:

01/01/07

Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,076 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 1

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

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

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

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

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

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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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	51,830	1999	\$ 5,000	1
2	Storage		2003	4,000	2
3	TOTALS	51,830		\$ 9,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo

# 0045583

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		1999	1972	\$ 345,000	\$ 8,625	40	\$ 8,625		\$ 76,188	4
5			2003	1936	40,111	1,003	40	1,003		4,354	5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalk		1999		798	80	10	80		692	9
10	Painting/Wallpaper		1999		5,350					5,350	10
11	Dish Tables		2002		1,744	174	10	174		1,017	11
12	Central Air System for Kitchen		2002		4,250	425	10	425		2,408	12
13	Flooring		2003		2,375	237	10	237		1,261	13
14	Commercial Water Heater		2005		4,663	466	10	466		1,321	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 404,291	\$ 11,010		\$ 11,010	\$	\$ 92,591	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 302,940	\$ 21,560	\$ 21,560	\$	5-15 yrs	\$ 179,249	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,783					1,783	73
74								74
75	TOTALS	\$ 304,723	\$ 21,560	\$ 21,560	\$		\$ 181,032	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	Transport residents	2000 Ford E-250HD Super Van	1999	\$ 36,009	\$	\$	\$		\$ 36,009	76
77										77
78										78
79										79
80	TOTALS			\$ 36,009	\$	\$	\$		\$ 36,009	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)	\$ 754,023	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,570	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,570	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)	\$ 309,632	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	New Flooring Deposit	\$ 2,000	92
93			93
94			94
95		\$ 2,000	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.

**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

\*\*

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

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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* 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.

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	852	\$ 45,898	\$	852	\$ 45,898	1
2	Licensed Speech and Language Development Therapist		hrs		99	5,413		99	5,413	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,092	116,016		2,092	116,016	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>			\$	3,043	\$ 167,327	\$	3,043	\$ 167,327	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo# 0045583Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 25,820	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	471,347		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,268		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 498,435	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,000		13
14	Buildings, at Historical Cost	40,111		14
15	Leasehold Improvements, at Historical Cost	15,032		15
16	Equipment, at Historical Cost	340,733		16
17	Accumulated Depreciation (book methods)	(227,402)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 172,474	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 670,909	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 112,665	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,054		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,796		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Insurance	27,076		36
37	Accrued Rent and Mgmt Fees	20,500		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 223,091	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Advances from Owners	312,488		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 312,488	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 535,579	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 135,330	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 670,909	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 106,819	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 106,819	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	101,717	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	(95,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <b>Prior Year Medicare Receivable recorded</b>	21,794	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 28,511</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 135,330</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo# 0045583Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 2,356,355	1
2	Discounts and Allowances for all Levels	(460,447)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,895,908</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,441	6
7	Oxygen	9,590	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 297,031</b>	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	5,458	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	206,286	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,781	19
20	Radiology and X-Ray		20
21	Other Medical Services	29,027	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 253,552</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,365	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,365</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Transportation Reimbursement	293	28
28a	Miscellaneous Income	240	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 533</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,449,389</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	427,170	31
32	Health Care	988,920	32
33	General Administration	593,248	33
<b>B. Capital Expense</b>			
34	Ownership	147,627	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	157,697	35
36	Provider Participation Fee	32,850	36
<b>D. Other Expenses (specify):</b>			
37	Other	160	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,347,672</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>101,717</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 101,717</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg. 26 If not, please attach a reconciliation.

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

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

Facility Name & ID Number Friendship Manor of St Elmo

# 0045583

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	1,936	2,080	\$ 49,036	\$ 23.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,399	6,742	112,581	16.70	3
4	Licensed Practical Nurses	12,404	13,233	192,041	14.51	4
5	CNAs & Orderlies	40,210	42,158	366,466	8.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,661	1,692	14,673	8.67	9
10	Activity Assistants	1,296	1,373	10,820	7.88	10
11	Social Service Workers	2,762	2,958	24,774	8.38	11
12	Dietician					12
13	Food Service Supervisor	1,467	1,635	18,851	11.53	13
14	Head Cook	528	531	4,000	7.53	14
15	Cook Helpers/Assistants	8,628	8,853	65,741	7.43	15
16	Dishwashers	712	728	4,772	6.55	16
17	Maintenance Workers	2,054	2,111	21,998	10.42	17
18	Housekeepers	6,847	7,298	60,432	8.28	18
19	Laundry	1,944	2,097	16,371	7.81	19
20	Administrator	2,080	2,080	65,270	31.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	930	964	7,740	8.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,858	96,533	\$ 1,035,566 *	\$ 10.73	34

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	109	\$ 5,585	01-3	35
36	Medical Director	72	9,600	09-3	36
37	Medical Records Consultant	32	800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	600	39-3	39
40	Physical Therapy Consultant	40	995	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,525	11-3	44
45	Social Service Consultant	50	2,525	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	377	\$ 22,630		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

\*\* See instructions.

Facility Name & ID Number Friendship Manor of St Elmo

# 0045583

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	
<u>Charles Hutson</u>	<u>Administrator</u>		\$ <u>65,270</u>	<u>Workers' Compensation Insurance</u>	\$ <u>57,742</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>11,742</u>	<u>Advertising: Employee Recruitment</u>	<u>5,500</u>	
				<u>FICA Taxes</u>	<u>77,562</u>	<u>Health Care Worker Background Check</u>	<u>288</u>	
				<u>Employee Health Insurance</u>	<u>31,914</u>	(Indicate # of checks performed <u>22</u> )		
				<u>Employee Meals</u>		<u>Advertising</u>	<u>3,479</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and Subscriptions</u>	<u>4,606</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>65,270</u>					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees - Rincker Healthcare</u>			\$ <u>144,000</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
							<u>Admin travel, employee mileage</u>	<u>6,592</u>
							<u>Less transportation reimbursement</u>	<u>(293)</u>
							<u>Seminar Expense</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>144,000</u>					
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
<u>Kamper CPA Group, LLP</u>	<u>Accounting</u>		\$ <u>15,160</u>				\$ <u>6,299</u>	
<u>James D. Stout</u>	<u>Legal</u>		<u>350</u>					
<u>Kemper Technology Consulting</u>	<u>Computer Services</u>		<u>1,005</u>					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ <u>16,515</u>					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Friendship Manor of St Elmo

# 0045583

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (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. \$ 32,850  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation. See Pg. 24  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Adjustments, line 29	<u>Amount</u>	<u>Line</u>
Transportation Reimbursement	293.00	24
Miscellaneous Income	<u>240.00</u>	21
	<u><u>533.00</u></u>	

Pg 15

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

SEE ACCOUNTANTS' COMPILATION REPORT.

Pg 23 line 16a

Out of state travel

The out-of-state travel is for transportation between the Florida residence of one of the owners and the nursing home location in Illinois.

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

<u>Line Description</u>	<u>Amount</u>	<u>Line Ref</u>
Administrative	34,730	17
Professional Services	1,233	19
Clerical & General Office Expenses	54,523	21
Employee Benefits & Payroll Taxes	3,222	22
Travel and Seminar	1,745	24
Insurance - Prop.Liab.Malpractice	271	26
Interest	788	32
Rent - Equipment & Vehicles	2,110	35
Donations	710	43
Administrative	<u>99,332</u>	17
Depreciation	8,705	30
Interest	<u>22,460</u>	32
Rent - Facility Grounds	<u>31,165</u>	34
Grand Total of allocated costs	<u><u>130,497</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT.

Reconciliation of taxable income to book net income

Book Net Income	\$ 101,717
Rounding	-3
Difference book vs. tax depreciation	19,663
Disallowed Meals & Entertainment	332
Accrual to cash conversion	<u>(54,892)</u>
Taxable Income	<u>\$ 66,817</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	6,996.00	6,996.00	6,996.00	40,813.00	9,795.00
West Grove	6,181.00	6,181.00	6,181.00	36,051.00	8,652.00
Lawrence Comm. Healthcare Center	12,827.00	12,827.00	12,827.00	74,823.00	101,608.00
Rincker Residential	6,996.00	6,996.00	6,996.00	40,813.00	9,795.00
	<u>33,000.00</u>	<u>33,000.00</u>	<u>33,000.00</u>	<u>192,500.00</u>	<u>129,850.00</u>
Salaries reported on this cost report	<u>6,996.00</u>	<u>6,996.00</u>	<u>6,996.00</u>	<u>40,813.00</u>	<u>9,795.00</u>
Salaries reported by other homes	<u><u>26,004.00</u></u>	<u><u>26,004.00</u></u>	<u><u>26,004.00</u></u>	<u><u>151,687.00</u></u>	<u><u>120,055.00</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building &amp; Improvements</u>	<u>Equipment</u>	<u>Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ 4,000	\$ 53,143	\$ 304,724	\$ 36,009	\$ 397,876
Schedule XI Ownership Costs	<u>9,000</u>	<u>404,291</u>	<u>304,724</u>	<u>36,009</u>	<u>754,024</u>
Difference	<u>\$ (5,000)</u>	<u>\$ (351,148)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (356,148)</u>

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

SEE ACCOUNTANTS' COMPILATION REPORT.

List of Related Parties (attachment to pg. 6)

**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
Angela West Trust	25%	West Grove, Inc.	Lawrenceville			
Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Angela West Trust	20%	Lawrence Community Healthcare Center	Bridgeport			
Mary Jane Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Mary Jane Rincker Trust	20%	Lawrence Community Healthcare Center	Bridgeport			
Deanna Gillis Trust	25%	West Grove, Inc.	Lawrenceville			
Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Deanna Gillis Trust	20%	Lawrence Community Healthcare Center	Bridgeport			
William J. Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
William J. Rincker Trust	20%	Lawrence Community Healthcare Center	Bridgeport			

SEE ACCOUNTANT'S COMPILATION REPORT.