

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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: 0045583

Facility Name: Friendship Manor of St Elmo

Address: 231 East Cumberland Road St Elmo 62458
 Number City Zip Code

County: Fayette

Telephone Number: (618) 829-5881 Fax # (618) 829-5569

HFS ID Number: 45583

Date of Initial License for Current Owners: 03/01/1999

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
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Charles R. Hutson</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>John S. Knoblett, CPA</u> <u>Partner</u>	
	(Firm Name & Address) <u>Kemper CPA Group LLP</u> <u>1701 Broadmoor, Suite 120, Champaign, IL 61821</u>	
	(Telephone) <u>(217) 351-2073</u> Fax # <u>(217) 351-3487</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	Phone # (217) 782-1630

In the event there are further questions about this report, please contact:
 Name: John Knoblett, CPA Telephone Number: (217) 351-2073
 Email Address: _____

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo

0045583 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	18	Intermediate (ICF)	18	6,588	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,837	4,812	2,692	17,341	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13

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

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

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

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

Day Care, Meals On Wheels

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

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

YES NO

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

YES NO

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

Date started 03/01/1999

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

YES Date 02/26/1999 NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 2,692

Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

14	TOTALS	9,837	4,812	2,692	17,341	14
----	--------	-------	-------	-------	--------	----

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.97%

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Friendship Manor of St Elmo

0045583

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	105,923	8,452	5,793	120,168		120,168		120,168		1
2	Food Purchase		95,420		95,420		95,420	(4,738)	90,682		2
3	Housekeeping	66,784	21,235		88,019		88,019		88,019		3
4	Laundry	16,843	8,768	30	25,641		25,641		25,641		4
5	Heat and Other Utilities			75,957	75,957		75,957		75,957		5
6	Maintenance	23,683	5,415	31,858	60,956		60,956		60,956		6
7	Other (specify):*										7
8	TOTAL General Services	213,233	139,290	113,638	466,161		466,161	(4,738)	461,423		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	747,683	39,024	493	787,200		787,200	(24)	787,176		10
10a	Therapy		337	231,545	231,882		231,882		231,882		10a
11	Activities	31,176	532	2,982	34,690		34,690		34,690		11
12	Social Services	26,083		2,623	28,706		28,706		28,706		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	804,942	39,893	247,243	1,092,078		1,092,078	(24)	1,092,054		16
	C. General Administration										
17	Administrative	67,371		144,000	211,371	(67,218)	144,153	(44,253)	99,900		17
18	Directors Fees										18
19	Professional Services			18,771	18,771	1,521	20,292		20,292		19
20	Dues, Fees, Subscriptions & Promotions			16,059	16,059		16,059	(5,422)	10,637		20
21	Clerical & General Office Expenses	10,115		65,401	75,516	51,546	127,062	(41,100)	85,962		21
22	Employee Benefits & Payroll Taxes			164,039	164,039	8,615	172,654		172,654		22
23	Inservice Training & Education			6,360	6,360		6,360		6,360		23
24	Travel and Seminar			8,560	8,560	1,506	10,066	(3,090)	6,976		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			45,743	45,743	283	46,026		46,026		26
27	Other (specify):*										27
28	TOTAL General Administration	77,486		468,933	546,419	(3,747)	542,672	(93,865)	448,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,095,661	179,183	829,814	2,104,658	(3,747)	2,100,911	(98,627)	2,002,284		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.

Facility Name & ID Number

Friendship Manor of St Elmo

#0045583

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
	D. Ownership											
30	Depreciation			25,069	25,069	8,705	33,774		33,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					20,983	20,983	(1,884)	19,099			32
33	Real Estate Taxes			19,566	19,566		19,566		19,566			33
34	Rent-Facility & Grounds			102,000	102,000	(29,600)	72,400	(72,400)				34
35	Rent-Equipment & Vehicles					2,111	2,111		2,111			35
36	Other (specify):*											36
37	TOTAL Ownership			146,635	146,635	2,199	148,834	(74,284)	74,550			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			113,940	113,940		113,940	(622)	113,318			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,920	32,920		32,920		32,920			42
43	Other (specify):* Contributions			173	173	1,548	1,721	(1,721)				43
44	TOTAL Special Cost Centers			147,033	147,033	1,548	148,581	(2,343)	146,238			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,095,661	179,183	1,123,482	2,398,326		2,398,326	(175,254)	2,223,072			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:

01/01/08

Ending:

12/31/08

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	\$ (24)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,607)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,884)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(131)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,378)	24		15
16	Personal Expenses (Including Transportation)	(622)	39		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(852)	24		19
20	Contributions	(1,721)	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	(41,003)	21		24
25	Fund Raising, Advertising and Promotional	(5,422)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg5A	(957)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,601)		\$	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)	(116,653)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (116,653)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (175,254)		37

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

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

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

BHF USE ONLY									
48		49		50		51		52	

SEE ACCOUNTANTS' COMPILATION REPORT

Friendship Manor of St Elmo

ID# 0045583

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Transportation Reimbursement	\$ (860)	24	1
2	Miscellaneous Income	(85)	21	2
3	Vending Income	(12)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23

24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(957)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor of St Elmo

0045583

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,738)	0	0	0	0	0	0	0	0	0	0	(4,738)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,738)	0	0	0	0	0	0	0	0	0	0	(4,738)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(24)	0	0	0	0	0	0	0	0	0	0	(24)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(24)	0	0	0	0	0	0	0	0	0	0	(24)	16
	C. General Administration													
17	Administrative	0	(44,253)	0	0	0	0	0	0	0	0	0	(44,253)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,422)	0	0	0	0	0	0	0	0	0	0	(5,422)	20
21	Clerical & General Office Expenses	(41,100)	0	0	0	0	0	0	0	0	0	0	(41,100)	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	(3,090)	0	0	0	0	0	0	0	0	0	0	(3,090)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(49,612)	(44,253)	0	(93,865)	28								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor of St Elmo

0045583

Report Period Beginning:

01/01/08

Ending:

12/31/08

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)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,884)	0	0	0	0	0	0	0	0	0	0	(1,884) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(72,400)	0	0	0	0	0	0	0	0	0	(72,400) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,884)	(72,400)	0	(74,284) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(622)	0	0	0	0	0	0	0	0	0	0	(622) 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):*	(1,721)	0	0	0	0	0	0	0	0	0	0	(1,721) 43
44	TOTAL Special Cost Centers	(2,343)	0	0	0	0	0	0	0	0	0	0	(2,343) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(58,601)	(116,653)	0	(175,254) 45								

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 Attached (Page 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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 144,000	Rincker Healthcare Corporation	100.00%	\$ 99,747	\$ (44,253)	1
2	V	34 Rent	102,000	William Rincker Trust		29,600	(72,400)	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			\$ 129,347	\$ * (116,653)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo # 0045583 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	29,504			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		123,272	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: 01/01/08

Ending: 12/31/08

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 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

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	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: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Financial Bank NA		X	Refinance Purchase	\$5,420.02	2/15/2007	\$ 357,666	\$ 276,360	01/15/2014	7.1250	\$ 20,895	1								
2												2								
3	First Financial Bank NA		X	Purchase - Rincker Healthcare							88	3								
4				See Page 25								4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$5,420.02		\$ 357,666	\$ 276,360			\$ 20,983	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 357,666	\$ 276,360			\$ 20,983	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.)

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>01-12-27-237-002</u>	<u>Land</u>	\$ <u>64.93</u>	\$ <u>64.93</u>
2. <u>01-12-27-237-003</u>	<u>Building & Land</u>	\$ <u>18,166.11</u>	\$ <u>18,166.11</u>
3. <u>01-12-27-237-004</u>	<u>Building & Land</u>	\$ <u>1,450.10</u>	\$ <u>1,450.10</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>19,681.14</u></u>	\$ <u><u>19,681.14</u></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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08 Ending:

12/31/08

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).

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:

01/01/08

Ending:

12/31/08

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	\$	\$ 84,813	4
5			2003	1936	40,111	1,003	40	1,003		5,357	5
6											6
7											7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets Thru 2008				5,350					5,350	9
10	Sidewalk		1999		798	80	10	80		772	10
11	Dish Tables		2002		1,744	174	10	174		1,191	11
12	Central Air System for Kitchen		2002		4,250	425	10	425		2,833	12
13	Flooring		2003		2,375	237	10	237		1,498	13
14	Commercial Water Heater		2005		4,663	466	10	466		1,787	14
15	New Flooring		2008		4,948	495	10	495		495	15
16	Water Heater		2008		6,558	656	10	656		656	16
17	Water Heater		2008		6,308	53	10	53		53	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

Facility Name & ID Number Friendship Manor of St Elmo

0045583

Report Period Beginning:

01/01/08 Ending:

12/31/08

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 422,105	\$ 12,214		\$ 12,214	\$	\$ 104,805	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$		\$ 200,809	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	\$		\$ 202,592	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)	\$ 771,837	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,774	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,774	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)	\$ 343,406	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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	TOTAL				\$ _____			7

**

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$	1,924	\$	110,311	\$	1,924	\$	110,311					1
2	Licensed Speech and Language Development Therapist		hrs		82		8,035		82		8,035					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs		2,173		113,199		2,173		113,199					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$	4,179	\$	231,545	\$	4,179	\$	231,545					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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Friendship Manor of St Elmo

0045583

Report Period Beginning: 01/01/08

Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 27,575	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	505,958		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,207		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 534,740	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,000		13
14	Buildings, at Historical Cost	40,111		14
15	Leasehold Improvements, at Historical Cost	30,845		15
16	Equipment, at Historical Cost	340,733		16
17	Accumulated Depreciation (book methods)	(252,471)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 163,218	\$	24

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 64,987	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,929		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,681		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Insurance & Tax Assessment</u>	18,741		36
37	<u>Accrued Rent & Mgmt Fees</u>	35,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 150,338	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Advances From Owners</u>	354,488		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 354,488	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 504,826	\$	46

25	TOTAL ASSETS (sum of lines 10 and 24)	\$	697,958	\$	25
----	---	----	---------	----	----

47	TOTAL EQUITY (page 18, line 24)	\$	193,132	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	697,958	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 135,330	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 135,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 157,802	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	\$ (100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 57,802	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 193,132	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo

0045583

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,387,481	1
2	Discounts and Allowances for all Levels	(393,706)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,993,775	3
	B. Ancillary Revenue		
4	Day Care	24	4
5	Other Care for Outpatients		5
6	Therapy	362,131	6
7	Oxygen	8,416	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 370,571	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	12	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,607	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	135,960	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,663	19
20	Radiology and X-Ray		20
21	Other Medical Services	37,710	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 188,952	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,884	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,884	26
	E. Other Revenue (specify):****		

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	466,161	31
32	Health Care	1,092,078	32
33	General Administration	546,419	33
	B. Capital Expense		
34	Ownership	146,635	34
	C. Ancillary Expense		
35	Special Cost Centers	113,940	35
36	Provider Participation Fee	32,920	36
	D. Other Expenses (specify):		
37	<u>Contributions</u>	173	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,398,326	40
41	Income before Income Taxes (line 30 minus line 40)**	157,802	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 157,802	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.

27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Reimbursement	860	28
28a	Miscellaneous Income	86	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 946	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,556,128	30

*** 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:

01/01/08

Ending:

12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,048	2,103	\$ 51,978	\$ 24.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,150	8,263	139,955	16.94	3
4	Licensed Practical Nurses	12,503	12,636	185,290	14.66	4
5	CNAs & Orderlies	41,521	42,021	370,462	8.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,741	1,751	15,915	9.09	9
10	Activity Assistants	1,712	1,783	15,261	8.56	10
11	Social Service Workers	3,187	3,265	26,083	7.99	11
12	Dietician					12
13	Food Service Supervisor	1,471	1,609	19,090	11.86	13
14	Head Cook	1,092	1,112	8,641	7.77	14
15	Cook Helpers/Assistants	9,442	9,481	74,427	7.85	15
16	Dishwashers	477	512	3,765	7.35	16
17	Maintenance Workers	2,105	2,182	23,683	10.85	17
18	Housekeepers	7,532	7,796	66,783	8.57	18
19	Laundry	1,959	2,105	16,842	8.00	19
20	Administrator	2,128	2,103	67,371	32.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,205	1,248	10,115	8.10	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

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	99	\$ 5,793	1-3	35
36	Medical Director	72	9,600	9-3	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	22	563	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,982	11-3	44
45	Social Service Consultant	48	2,623	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	350	\$ 22,961		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

34	TOTAL (lines 1 - 33)	98,273	99,970	\$ 1,095,661 *	\$ 10.96	34	SEE ACCOUNTANTS' COMPILATION REPORT
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* 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: 01/01/08

Ending: 12/31/08

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	
Charles Hutson	Administrator		\$ 67,371	Workers' Compensation Insurance	\$ 38,797	IDPH License Fee	\$	
				Unemployment Compensation Insurance	14,801	Advertising: Employee Recruitment	3,898	
				FICA Taxes	90,086	Health Care Worker Background Check	333	
				Employee Health Insurance	28,970	(Indicate # of checks performed <u>19</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	5,422	
						Dues & Subscriptions	4,166	
						License Fees	2,240	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,371			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(5,422)	
Description			Amount			Yellow page advertising	()	
Management Fees - Rincker Healthcare			\$ 144,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 144,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 172,654	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,637	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Kemper CPA Group LLP	Accounting		\$ 18,608			\$	Out-of-State Travel	\$
James D. Stout	Legal		163					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,771	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,976

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

****See instructions.**

Facility Name & ID Number Friendship Manor of St Elmo

Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Manor of St Elmo

0045583

Report Period Beginning:

01/01/08

Ending:

12/31/08

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? No 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? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. \$ 32,920
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
- (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? Yes
If YES, attach a complete explanation. See Page 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

for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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.

Page 15

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

Page 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.

SEE ACCOUNTANTS' COMPILATION REPORT.

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

<u>Line Description</u>	<u>Amount</u>	<u>Line Ref</u>
Administrative	\$ 32,529	17
Professional Services	1,521	19
Clerical & General Office Expenses	51,546	21
Employee Benefits & Payroll Taxes	8,615	22
Travel and Seminar	1,506	24
Insurance - Prop.Liab.Malpractice	283	26
Interest	88	32
Rent - Equipment & Vehicles	2,110	35
Donations	1,548	43
Administrative	<u>99,747</u>	17
Depreciation	8,705	30
Interest	20,895	32
Rent - Facility Grounds	<u>29,600</u>	34
Grand Total of allocated costs	<u>\$ 129,347</u>	

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 19, Reconciliation of taxable income to book net income

Book Net Income	\$ 157,802
Rounding	1
Difference book vs. tax depreciation	11,536
Disallowed Meals & Entertainment	249
A/P Taken From Other Balance Sheet Accounts	(2,037)
Accrual to cash conversion	<u>(107,812)</u>
Taxable Income	<u><u>\$ 59,739</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes.

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	\$ 6,996.00	\$ 6,996.00	\$ 6,996.00	\$ 40,813.00	\$ 9,795.00
West Grove	6,181.00	6,181.00	9,681.00	36,051.00	8,652.00
Lawrence Comm. Healthcare Center	12,827.00	12,827.00	12,827.00	74,823.00	104,825.00
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>36,500.00</u>	<u>192,500.00</u>	<u>133,067.00</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>\$ 29,504.00</u></u>	<u><u>\$ 151,687.00</u></u>	<u><u>\$ 123,272.00</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building & Improvements</u>	<u>Equipment</u>	<u>Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ 4,000	\$ 70,956	\$ 304,724	\$ 36,009	\$ 415,689
Schedule XI Ownership Costs	<u>9,000</u>	<u>422,105</u>	<u>304,724</u>	<u>36,009</u>	<u>771,838</u>
Difference	<u>\$ (5,000)</u>	<u>\$ (351,149)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (356,149)</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 ACCOUNTANTS' COMPILATION REPORT.