

Facility Name & ID Number FARMINGTON COUNTRY MANOR

0045187 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	11,378	13,511	4,179	29,068	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	11,378	13,511	4,179	29,068	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

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

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

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

N/A

F. Does the facility maintain a daily midnight census? 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 12/01/1995

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 92 and days of care provided 3,128

Medicare Intermediary RIVERBEND GOVERNMENT BENEFIT ADMINISTRATOR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number **FARMINGTON COUNTRY MANOR** # **0045187** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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	211,357	20,787	18,225	250,369		250,369		250,369		1
2	Food Purchase		166,215		166,215		166,215	(429)	165,786		2
3	Housekeeping	117,582	15,509		133,091		133,091		133,091		3
4	Laundry	64,239	13,289		77,528		77,528		77,528		4
5	Heat and Other Utilities			115,119	115,119		115,119		115,119		5
6	Maintenance	57,029	20,663	40,400	118,092		118,092		118,092		6
7	Other (specify):*										7
8	TOTAL General Services	450,207	236,463	173,744	860,414		860,414	(429)	859,985		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,409,371	131,391	40,182	1,580,944		1,580,944		1,580,944		10
10a	Therapy	69,510	2,912	319,399	391,821		391,821		391,821		10a
11	Activities	58,712	7,588	800	67,100		67,100		67,100		11
12	Social Services	60,258			60,258		60,258		60,258		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,597,851	141,891	378,381	2,118,123		2,118,123		2,118,123		16
	C. General Administration										
17	Administrative	82,666		354,328	436,994		436,994	(151,646)	285,348		17
18	Directors Fees										18
19	Professional Services			2,686	2,686		2,686	14,866	17,552		19
20	Dues, Fees, Subscriptions & Promotions			29,692	29,692	570	30,262	(19,066)	11,197		20
21	Clerical & General Office Expenses	174,102	12,710	136,792	323,604		323,604	(77,058)	246,546		21
22	Employee Benefits & Payroll Taxes			427,070	427,070	(570)	426,500	36,815	463,315		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,448	1,448		1,448		1,448		24
25	Other Admin. Staff Transportation			13,324	13,324		13,324		13,324		25
26	Insurance-Prop.Liab.Malpractice			36,188	36,188		36,188		36,188		26
27	Other (specify):*										27
28	TOTAL General Administration	256,768	12,710	1,001,528	1,271,006		1,271,006	(196,089)	1,074,918		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,304,826	391,064	1,553,653	4,249,543		4,249,543	(196,518)	4,053,026		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			149,770	149,770		149,770	361	150,131			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,957	182,957	(13,037)	169,920	(1,796)	168,124			32
33	Real Estate Taxes			50,298	50,298		50,298	2,620	52,918			33
34	Rent-Facility & Grounds							6,317	6,317			34
35	Rent-Equipment & Vehicles			7,110	7,110		7,110		7,110			35
36	Other (specify):* Mortgage Ins					13,037	13,037		13,037			36
37	TOTAL Ownership			390,135	390,135		390,135	7,502	397,637			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,840	110,812	121,652		121,652		121,652			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,370	50,370		50,370		50,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		10,840	161,182	172,022		172,022		172,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,304,826	401,904	2,104,970	4,811,700		4,811,700	(189,016)	4,622,685			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,651)	21		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	(1,796)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(429)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,088)	21		24
25	Fund Raising, Advertising and Promotional	(18,953)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,917)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (105,917)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					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

FARMINGTON COUNTRY MANOR

ID# 0045187

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	CHAMBER OF COMMERCE DUES	\$ (113)	20	1
2	REAL ESTATE TAX ADJUST TO ACTUAL	2,620	33	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,508		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FARMINGTON COUNTRY MANOR# 0045187

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(429)	0	0	0	0	0	0	0	0	0	0	(429)	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	(429)	0	0	0	0	0	0	0	0	0	0	(429)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(151,646)	0	0	0	0	0	0	0	0	0	(151,646)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,866	0	0	0	0	0	0	0	0	0	14,866	19
20	Fees, Subscriptions & Promotions	(19,066)	0	0	0	0	0	0	0	0	0	0	(19,066)	20
21	Clerical & General Office Expenses	(84,739)	7,681	0	0	0	0	0	0	0	0	0	(77,058)	21
22	Employee Benefits & Payroll Taxes	0	36,815	0	0	0	0	0	0	0	0	0	36,815	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	(103,805)	(92,284)	0	(196,089)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(104,234)	(92,284)	0	(196,518)	29								

STATE OF ILLINOIS

Facility Name & ID Number FARMINGTON COUNTRY MANOR# 0045187

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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	361	0	0	0	0	0	0	0	0	0	361	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,796)	0	0	0	0	0	0	0	0	0	0	(1,796)	32
33	Real Estate Taxes	2,620	0	0	0	0	0	0	0	0	0	0	2,620	33
34	Rent-Facility & Grounds	0	6,317	0	0	0	0	0	0	0	0	0	6,317	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	824	6,678	0	7,502	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	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(103,410)	(85,606)	0	0	0	0	0	0	0	0	0	(189,016)	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
AMERICAN HEALTH CORPORATION	100	OAK TRACE				
AMERICAN HEALTH CORPORATION	100	TERRACE OAKS				
AMERICAN HEALTH CORPORATION	100	COLONIAL HAVEN				
AMERICAN HEALTH CORPORATION	100	RAINBOW OF NJ, INC.				
AMERICAN HEALTH CORPORATION	100	ROSEVILLE COUNTRY MANOR, INC.	ROSEVILLE, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1	DIETARY	\$ 18,225	AMERICAN HEALTH CORPORATION	100.00%	\$ 18,225		1
2	V	17	ADMINISTRATIVE	354,328	AMERICAN HEALTH CORPORATION	100.00%	202,682	(151,646)	2
3	V	19	PROFESSIONAL SERVICES		AMERICAN HEALTH CORPORATION	100.00%	14,866	14,866	3
4	V	21	CLERICAL & GEN OFFICE		AMERICAN HEALTH CORPORATION	100.00%	7,681	7,681	4
5	V	22	EMP BENEFITS & TAXES		AMERICAN HEALTH CORPORATION	100.00%	36,815	36,815	5
6	V	34	RENT - FACILITY		AMERICAN HEALTH CORPORATION	100.00%	6,317	6,317	6
7	V	30	DEPRECIATION		AMERICAN HEALTH CORPORATION	100.00%	361	361	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 372,553				\$ 286,947	\$ * (85,606)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FARMINGTON COUNTRY MANOR

0045187

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 AMERICAN HEALTH CORPORATION
 Street Address 527 PLYMOUTH ROAD, SUITE 412
 City / State / Zip Code PLYMOUTH MEETING, PA 19462
 Phone Number (610-832-2059
 Fax Number (610-834-2937

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	PATIENT DAYS	153,650	6	\$ 1,071,355	\$ 854,196	29,068	\$ 202,682	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	153,650	6	78,578		29,068	14,866	2
3	21	CLERICAL & GEN OFFICE	PATIENT DAYS	153,650	6	40,602		29,068	7,681	3
4	22	EMPLOYEE BENEFITS & TAX	PATIENT DAYS	153,650	6	194,601		29,068	36,815	4
5	34	RENT - FACILITY	PATIENT DAYS	153,650	6	33,391		29,068	6,317	5
6	30	DEPRECIATION	PATIENT DAYS	153,650	6	1,907		29,068	361	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					\$ 1,420,434	\$ 854,196		\$ 268,722	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

FARMINGTON COUNTRY MANOR

0045187

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										
										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	CAPMARK FINANCE		X	MORTGAGE	\$31,132.00		\$ 3,017,500	\$ 2,591,650	03/01/2029	6.1500	\$ 168,124	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$31,132.00		\$ 3,017,500	\$ 2,591,650			\$ 168,124	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,017,500	\$ 2,591,650			\$ 168,124	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 13,037 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR

0045187

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,000 B. General Construction Type: Exterior Brick Frame Steel 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	<u>NURSING FACILITY</u>		<u>7/28/1986</u>	<u>\$ 34,115</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 34,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	92	1986		\$ 2,264,583	\$ 75,486	30	\$ 75,486	\$	\$ 1,775,011	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	1987 ADDITIONS	1987		2,769	110	VARIOUS	110		2,500	9
10	1988 ADDITIONS	1988		50,953	1,674	VARIOUS	1,674		37,911	10
11	1989 ADDITIONS	1989		36,365	864	VARIOUS	864		35,718	11
12	1990 ADDITIONS	1990		11,397		15			11,397	12
13	1991 ADDITIONS	1991		41,089		15			41,089	13
14	1992 ADDITIONS	1992		4,778		15			4,778	14
15	1993 ADDITIONS	1993		4,673		15			4,673	15
16	1994 ADDITIONS	1994		17,596	555	15	555		16,921	16
17	1995 ADDITIONS	1995		1,742	116	15	116		1,683	17
18	CARPET	2001		300		3			300	18
19										19
20	ROOF	2003		28,208	723	39	723		4,701	20
21	PAVING PARKING LOT	2003		41,839	2,791	15	2,791		22,719	21
22	PARKING LOT	2006		4,890	125	39	125		401	22
23	LEASEHOLD IMPROVEMENTS	2007		4,250	109	39	109		304	23
24	FIVE STAR	2008		41,366	2,759	15	2,759		4,136	24
25										25
26	LEASEHOLD IMPROVEMENTS	2009		22,548	217	39	217		217	26
27	LEASEHOLD IMPROVEMENTS	2009		5,132	5	39	5		5	27
28	LEASEHOLD IMPROVEMENTS	2009		19,295	21	39	21		21	28
29	LEASEHOLD IMPROVEMENTS	2009		1,582	2	39	2		2	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	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)		\$ 2,605,355	\$ 85,557		\$ 85,557	\$	\$ 1,964,487	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	\$ 655,904	\$ 50,097	\$ 50,097	\$		\$ 551,212	71
72	Current Year Purchases	57,412	5,089	5,089			5,089	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 713,316	\$ 55,186	\$ 55,186	\$		\$ 556,301	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	NURSING FACILITY VAN	VAN	2007	\$ 45,133	\$ 9,027	\$ 9,027	\$	5	\$ 22,567	76
77										77
78										78
79										79
80	TOTALS			\$ 45,133	\$ 9,027	\$ 9,027	\$		\$ 22,567	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,397,919	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 149,770	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 149,770	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,543,355	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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?</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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	1,590	\$ 91,632	\$	1,590	\$ 91,632	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		921	53,076		921	53,076	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		3,032	174,691	2,912	3,032	177,603	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				109,762		109,762	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Laboratory</u>	39					10,840		10,840	12
13	Other (specify): <u>Radiology</u>	39					1,050		1,050	13
14	TOTAL			\$	5,544	\$ 319,399	\$ 124,564	5,544	\$ 443,963	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009**

(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	\$ 402,943	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>69,037</u>)	353,261		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,958		6
7	Other Prepaid Expenses	3,587		7
8	Accounts Receivable (owners or related parties)	2,026,786		8
9	Other(specify): DUE FROM MEDICARE	(12,832)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,775,703	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,115		13
14	Buildings, at Historical Cost	2,264,583		14
15	Leasehold Improvements, at Historical Cost	340,772		15
16	Equipment, at Historical Cost	758,449		16
17	Accumulated Depreciation (book methods)	(2,543,355)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	152,936		21
22	Other Long-Term Assets (spe <u>LOAN COSTS</u>)	120,037		22
23	Other(specify): Rounding	1		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,127,538	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,903,241	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 170,846	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	79,461		29
30	Accrued Salaries Payable	161,559		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	OTHER ACCRUED EXPENSES	14,912		36
37	DUE TO IL DEPT OF PUBLIC AID	74,166		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 551,344	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,512,188		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,512,188	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,063,532	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 839,709	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,903,241	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 540,651	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 540,651	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	299,058	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 299,058	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)	\$ 839,709	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **FARMINGTON COUNTRY MANOR**# **0045187**Report Period Beginning: **01/01/2009**Ending: **12/31/2009**

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	\$ 4,432,229	1
2	Discounts and Allowances for all Levels	(186,902)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,245,327	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	619,335	6
7	Oxygen	14,582	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 633,917	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,602	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	77,097	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,699	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	45,815	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 45,815	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,110,758	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	860,414	31
32	Health Care	2,118,123	32
33	General Administration	1,271,006	33
B. Capital Expense			
34	Ownership	390,135	34
C. Ancillary Expense			
35	Special Cost Centers	121,652	35
36	Provider Participation Fee	50,370	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,811,700	40
41	Income before Income Taxes (line 30 minus line 40)**	299,058	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 299,058	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 **FARMINGTON COUNTRY MANOR**

0045187

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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	1,808	2,080	\$ 72,180	\$ 34.70	1
2	Assistant Director of Nursing	1,840	2,080	55,977	26.91	2
3	Registered Nurses	3,792	4,386	96,606	22.03	3
4	Licensed Practical Nurses	21,692	24,896	531,597	21.35	4
5	CNAs & Orderlies	53,029	60,275	627,290	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	2,120	32,431	15.30	9
10	Activity Assistants	2,416	2,768	26,281	9.49	10
11	Social Service Workers	3,686	4,107	60,258	14.67	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,080	34,802	16.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,363	18,868	176,555	9.36	15
16	Dishwashers					16
17	Maintenance Workers	3,109	3,706	57,029	15.39	17
18	Housekeepers	10,895	12,477	117,582	9.42	18
19	Laundry	5,731	6,430	64,239	9.99	19
20	Administrator	1,792	2,080	82,666	39.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,185	8,320	174,102	20.93	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	1,844	2,133	25,721	12.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,862	158,806	\$ 2,235,316 *	\$ 14.08	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	288	\$ 18,225	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	24	9,688	10-3	38
39	Pharmacist Consultant	192	5,311	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	800	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	608	\$ 52,024		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JENNIFER WILDER	ADMINISTRATOR	N/A	\$ 82,666	Workers' Compensation Insurance	\$ 69,467	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,176	Advertising: Employee Recruitment		
				FICA Taxes	158,392	Health Care Worker Background Check		
				Employee Health Insurance	179,465	(Indicate # of checks performed <u>57</u>)	570	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		MARKETING	18,953	
						IHCA DUES	4,655	
						OTHER DUES & SUBSCRIPTIONS	5,972	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,666	Health ins & taxes from Central Office	36,815			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising (18,953)	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				TOTAL (agree to Sch. V, line 20, col. 8)	
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
MELISSA THURMAN	ACCOUNTING		\$ 2,348			\$	Out-of-State Travel	\$
FROEHLING, WEBER, EVANS & ASSOCIATES	LEGAL FEES		338					
							In-State Travel	
							ADMINISTRATIVE TRAVEL	508
							Seminar Expense	
							ADMIN SEMINAR EXPENSE	940
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,686	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,448	

* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
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 FARMINGTON COUNTRY MANOR

0045187

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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? YES
If YES, give association name and amount. IHCA - \$4,655
- (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? N/A
- (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? N/A
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,800 Line 10
- (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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
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. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- 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. \$ 0
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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