

Facility Name & ID Number Farmington Country Manor

0045187 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			4,274	4,274	8
9	SNF/PED					9
10	ICF	12,340	9,863		22,203	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,340	9,863	4,274	26,477	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.85%

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

None (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)

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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 2,224

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Farmington Country Manor

0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	213,032	23,046	14,666	250,744		250,744	250,744			1
2	Food Purchase		172,457		172,457		172,457	172,457			2
3	Housekeeping	121,992	19,273		141,265		141,265	141,265			3
4	Laundry	64,824	23,543		88,367		88,367	88,367			4
5	Heat and Other Utilities			89,131	89,131		89,131	89,131			5
6	Maintenance	70,117	65,946	24,440	160,503		160,503	(25,306)	135,197		6
7	Other (specify):*										7
8	TOTAL General Services	469,965	304,265	128,237	902,467		902,467	(25,306)	877,161		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	1,481,594	101,712	13,003	1,596,309		1,596,309	(1,626)	1,594,683		10
10a	Therapy		604	363,909	364,513		364,513	364,513			10a
11	Activities	46,604	7,621	200	54,425		54,425	54,425			11
12	Social Services	45,721			45,721		45,721	45,721			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,573,919	109,937	389,112	2,072,968		2,072,968	(1,626)	2,071,342		16
	C. General Administration										
17	Administrative	101,724		402,889	504,613		504,613	(243,864)	260,749		17
18	Directors Fees										18
19	Professional Services			60,447	60,447		60,447	1,562	62,009		19
20	Dues, Fees, Subscriptions & Promotions			19,213	19,213		19,213	(2,274)	16,939		20
21	Clerical & General Office Expenses	181,657	13,264	29,724	224,645		224,645	118,786	343,431		21
22	Employee Benefits & Payroll Taxes			345,338	345,338		345,338	39,601	384,939		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,877	8,877		8,877	(7,612)	1,265		24
25	Other Admin. Staff Transportation			8,931	8,931		8,931	761	9,692		25
26	Insurance-Prop.Liab.Malpractice			68,006	68,006		68,006	68,006	68,006		26
27	Other (specify):*										27
28	TOTAL General Administration	283,381	13,264	943,425	1,240,070		1,240,070	(93,040)	1,147,030		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,327,265	427,466	1,460,774	4,215,505		4,215,505	(119,972)	4,095,533		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 Farmington Country Manor

#0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

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							202,940	202,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,061	1,061		1,061	108,217	109,278			32
33	Real Estate Taxes			75,916	75,916		75,916		75,916			33
34	Rent-Facility & Grounds			312,440	312,440		312,440	(305,154)	7,286			34
35	Rent-Equipment & Vehicles			28,555	28,555		28,555		28,555			35
36	Other (specify):* Mortgage Ins							14,065	14,065			36
37	TOTAL Ownership			417,972	417,972		417,972	20,068	438,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,294		131,294		131,294		131,294			39
40	Barber and Beauty Shops			816	816		816		816			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,882	178,882		178,882		178,882			42
43	Other (specify):* Non-allowable Costs			275,635	275,635		275,635	(275,635)				43
44	TOTAL Special Cost Centers		131,294	455,333	586,627		586,627	(275,635)	310,992			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,327,265	558,760	2,334,079	5,220,104		5,220,104	(375,539)	4,844,565			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 Farmington Country Manor

0045187

Report Period Beginning: 1/1/15

Ending: 12/31/15

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	(8,843)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,009	30		9
10	Interest and Other Investment Income	(301)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,601)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,832)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(241,014)	43		24
25	Fund Raising, Advertising and Promotional	(13,081)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(47,437)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (306,100)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(69,439)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (69,439)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (375,539)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Farmington Country Manor

ID# 0045187

Report Period Beginning: 1/1/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Out of State Travel	\$ (7,612)	24	1
2	Disallow Laboratory Expense	(8,906)	43	2
3	Disallow Xray Expense	(3,791)	43	3
4	Capitalize fixed assets for Medicaid basis	(25,306)	6	4
5	Offset Miscellaneous income against expense	(1,822)	21	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		(47,437)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Farmington Country Manor# 0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(25,306)	0	0	0	0	0	0	0	0	0	0	(25,306)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(25,306)	0	0	0	0	0	0	0	0	0	0	(25,306)	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	(1,626)	0	0	0	0	0	0	0	0	(1,626)	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	(1,626)	0	(1,626)	16							
	C. General Administration													
17	Administrative	0	(243,864)	0	0	0	0	0	0	0	0	0	(243,864)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,832)	7,394	0	0	0	0	0	0	0	0	0	1,562	19
20	Fees, Subscriptions & Promotions	(2,601)	327	0	0	0	0	0	0	0	0	0	(2,274)	20
21	Clerical & General Office Expenses	(1,822)	120,608	0	0	0	0	0	0	0	0	0	118,786	21
22	Employee Benefits & Payroll Taxes	0	38,736	865	0	0	0	0	0	0	0	0	39,601	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,612)	0	0	0	0	0	0	0	0	0	0	(7,612)	24
25	Other Admin. Staff Transportation	0	0	761	0	0	0	0	0	0	0	0	761	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	(17,867)	(76,799)	1,626	0	(93,040)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,173)	(76,799)	0	0	0	0	0	0	0	0	0	(119,972)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Farmington Country Manor# 0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	13,009	6	0	189,925	0	0	0	0	0	0	0	202,940	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(301)	68	0	108,450	0	0	0	0	0	0	0	108,217	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	7,286	0	(312,440)	0	0	0	0	0	0	0	(305,154)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	14,065	0	0	0	0	0	0	0	14,065	36
37	TOTAL Ownership	12,708	7,360	0	20,068	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):*	(275,635)	0	0	0	0	0	0	0	0	0	0	(275,635)	43
44	TOTAL Special Cost Centers	(275,635)	0	0	0	0	0	0	0	0	0	0	(275,635)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(306,100)	(69,439)	0	0	0	0	0	0	0	0	0	(375,539)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
American Health Corpotation	100	Oak Trace	Alabama	Midwest Health	Farmington	Real Estate entity
		Terrace Oaks	Alabama	of Farmington		
		Colonial Haven	Alabama			
		Rainbow of New Jersey, Inc.	New Jersey			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Administrative	\$ 402,889	American Health Corpotation	100.00%	\$ 159,025	\$ (243,864)	1
2	V	19 Professional Services		American Health Corpotation	100.00%	7,394	7,394	2
3	V	20 Dues & Subscriptions		American Health Corpotation	100.00%	327	327	3
4	V	21 Clerical & Gen Office		American Health Corpotation	100.00%	120,607	120,608	4
5	V	22 Emp Benefits & P/R Taxes		American Health Corpotation	100.00%	38,736	38,736	5
6	V	30 Depreciation		American Health Corpotation	100.00%	6	6	6
7	V	32 Interest		American Health Corpotation	100.00%	68	68	7
8	V	34 Rent - Facility		American Health Corpotation	100.00%	7,286	7,286	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 402,889			\$ 333,449	\$ * (69,439)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing and Medical Records	\$ 7,251	American Health Corpotation	100.00%	\$ 5,625	\$ (1,626)	15
16	V	22 Employee Benefits & PR Taxes		American Health Corpotation	100.00%	865	865	16
17	V	25 Other Admin Staff Transport.		American Health Corpotation	100.00%	761	761	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,251			\$ 7,251	\$ * 0	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Midwest Health of Farmington	0.00%	\$ 189,925	\$ 189,925	15
16	V	32 Interest Expense	33	Midwest Health of Farmington	0.00%	108,483	108,450	16
17	V	34 Rent	312,440	Midwest Health of Farmington	0.00%		(312,440)	17
18	V	36 Mortgage Insurance		Midwest Health of Farmington	0.00%	14,065	14,065	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 312,473			\$ 312,473	\$ * 0	39

* 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: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stanley Stein	Ceo	Administrative	23.89	377,617	8	20.00	Mgmt Fee	\$ 97,383	L17, C7	1
2	Gary Stein	Vice President	Administrative	0.00	194,972	8	20.00	Mgmt Fee	50,281	L17, C7	2
3	Jodi Stein	Admin Asst	Administrative	0.00	44,056	8	20.00	Mgmt Fee	11,361	L17, C7	3
4											4
5											5
6											6
7	Note: All owner/relative wages are allocated from American Health Corporation.										7
8											8
9	See Attached Schedule 7A										9
10											10
11											11
12											12
13								TOTAL	\$ 159,025		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

Farmington Country Manor

Period Beginning 1/1/15
Period End 12/31/15

Schedule 7A

C. Statement of Compensation and Other Payments to Owners, Relatives

	Oak Trace	Terrace Oaks	Colonial Haven	Farmington Country Manor	Rainbow of New Jersey, Inc.	Total
Stanley Stein	92,778	79,662	107,744	97,383	97,434	475,000
Gary Stein	47,903	41,131	55,630	50,281	50,307	245,253
Jodi Stein	10,824	9,294	12,570	11,361	11,367	55,417
	<hr/> 151,505	<hr/> 130,087	<hr/> 175,944	<hr/> 159,025	<hr/> 159,109	<hr/> 775,670

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization American Health Corporation
 Street Address 527 Plymouth Road, Suite 412
 City / State / Zip Code Plymouth Meeting, PA 19462
 Phone Number (610) 832-2059
 Fax Number (610) 834-2937

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Administrative	Resident Days	129,146	5	\$ 775,670	\$ 775,670	26,477	\$ 159,025	1
2	19	Professional Services	Resident Days	129,146	5	36,065	26,477	26,477	7,394	2
3	20	Dues & Subscriptions	Resident Days	129,146	5	1,593	26,477	26,477	327	3
4	21	Clerical & Gen Office	Resident Days	129,146	5	588,286	442,690	26,477	120,607	4
5	22	Emp Benefits & P/R Taxes	Resident Days	129,146	5	188,943	26,477	26,477	38,736	5
6	30	Depreciation	Resident Days	129,146	5	31	26,477	26,477	6	6
7	32	Interest	Resident Days	129,146	5	333	26,477	26,477	68	7
8	34	Rent - Facility	Resident Days	129,146	5	35,537	26,477	26,477	7,286	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					\$ 1,626,458	\$ 1,218,360		\$ 333,449	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization American Health Corporation
 Street Address 527 Plymouth Road, Suite 412
 City / State / Zip Code Plymouth Meeting, PA 19462
 Phone Number (610) 832-2059
 Fax Number (610) 834-2937

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	10	Nursing and Medical Records	Direct Cost	112,500	5	\$ 112,500	\$ 112,500	5,625	\$ 5,625	1
2	22	Employee Benefits & PR Taxes	Direct Cost	17,305	5	17,305	865	865	865	2
3	25	Other Admin Staff Transport.	Direct Cost	15,212	5	15,212	761	761	761	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					\$ 145,017	\$ 112,500		\$ 7,251	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	BERKADIA COMM MORT		X	LAND, BUILDING, EQUIP	\$31,452.00		\$ 3,017,500	\$ 2,725,046	03/01/2029	6.1500	\$ 100,611					
2																
3																
4																
5																
Working Capital																
6	BANK OF FARMINGTON		X	Vehicle	\$773.00	10/25/13	42,464	24,950	11/1/18	3.5680	1,061					
7																
8																
9	TOTAL Facility Related				\$32,225.00		\$ 3,059,964	\$ 2,749,996			\$ 101,672					
B. Non-Facility Related*																
10											Amortization of Loan Costs 7,872					
11											Interest Income offset (334)					
12											Allocated from American Health Corp 68					
13																
14	TOTAL Non-Facility Related						\$	\$			\$ 7,606					
15	TOTALS (line 9+line14)						\$ 3,059,964	\$ 2,749,996			\$ 109,278					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 14,065 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2014 report.				\$	53,868	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2014		\$	64,892	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	11,024	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	64,892	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	75,916	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2010	<u>50,509</u>	8	FOR BHF USE ONLY			
	2011	<u>51,386</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014	\$	13
	2012	<u>53,216</u>	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2013	<u>53,868</u>	11	15	LESS REFUND FROM LINE 6	\$	15
	2014	<u>64,892</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
Accrual based on prior year tax bill.							

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Farmington Country Manor COUNTY Fulton
 FACILITY IDPH LICENSE NUMBER 0045187
 CONTACT PERSON REGARDING THIS REPORT Robert Conner, CFO
 TELEPHONE (610) 832-2059 FAX #: (610) 834-2937

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-04-12-300-013</u>	<u>LAND & BUILDING</u>	\$ <u>63,941.78</u>	\$ <u>63,941.78</u>
2. <u>05-04-12-300-002</u>	<u>LAND & BUILDING</u>	\$ <u>721.04</u>	\$ <u>721.04</u>
3. <u>05-04-12-300-017</u>	<u>LAND & BUILDING</u>	\$ <u>23.96</u>	\$ <u>23.96</u>
4. <u>05-04-12-300-016</u>	<u>LAND & BUILDING</u>	\$ <u>205.26</u>	\$ <u>205.26</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>64,892.04</u></u>	\$ <u><u>64,892.04</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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Farmington Country Manor

0045187 Report Period Beginning:

1/1/15 Ending:

12/31/15

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility</u>		<u>31621</u>	<u>\$ 34,115</u>	1
2					2
3	TOTALS			\$ 34,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
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	\$	\$ 2,227,927	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1987 Additions		1987	2,769		25			2,769	9
10	1988 Additions		1988	50,953	1,474	VARIOUS	1,474		48,181	10
11	1989 Additions		1989	36,365		VARIOUS	759	759	36,365	11
12	1990 Additions		1990	11,397		15			11,397	12
13	1991 Additions		1991	41,089		15			41,089	13
14	1992 Additions		1992	4,778		15			4,778	14
15	1993 Additions		1993	4,673		15			4,673	15
16	1994 Additions		1994	17,596		15			16,921	16
17	1995 Additions		1995	1,742		15			1,742	17
18	Carpet		2001	300		3			300	18
19										19
20	Roof		2003	28,208	723	39	723		9,039	20
21	Paving Parking Lot		2003	41,839	2,791	15	2,791		39,465	21
22	Parking Lot		2006	4,890	125	39	125		1,151	22
23	Paving /Blacktopping		2007	4,250	109	39	109		958	23
24	Roof		2008	41,366	2,759	15	2,759		20,690	24
25										25
26	Venting		2009	22,548	578	39	578		3,685	26
27	Blinds And Window Treatments		2009	5,132	132	39	132		797	27
28	Dining Room Floor		2009	19,295	495	39	495		2,991	28
29	Venting Materials		2009	1,582	41	39	41		248	29
30	Leasehold Improvement		2010	1,122	160	7	160		880	30
31	Nurse Call Station		2010	4,600	307	15	307		1,688	31
32	Nurse Call Station		2010	21,526	1,436	15	1,436		7,897	32
33	Carpet		2010	1,927	275	7	275		1,513	33
34										34
35	Nursing Hallway - Floor Tiles		2011	1,319	34	39	34		166	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 Farmington Country Manor

0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Outside - Seal Coating, Benches, Landscaping Rock	2012	\$ 9,754	\$ 250	39	\$ 250	\$	\$ 886	37
38	Outside - Concrete Installation, Fencing, Sign	2012	11,473	294	39	294		1,042	38
39	Therapy Room Flooring	2012	3,494	90	39	90		311	39
40	Architect Fees For Therapy Room Hallway	2012	1,954	50	39	50		152	40
41	Shower Room Upgrade (200-300 Wing) Gutted and installed	2012	25,250	647	39	647		1,968	41
42	flooring, file, drywall, cabinets, tub, lighting								42
43	Architect Fees-Therapy Room Hallway	2013	1,338	34	39	34		98	43
44	Sprinkler System-200 Wing	2013	8,914	229	39	229		658	44
45	New Plumbing System-Piping/Shutoff Valves throughout	2013	11,203	287	39	287		802	45
46	New Plumbing System-Piping/Shutoff Valves throughout	2013	4,002	103	39	103		287	46
47	New Hardwood Flooring-Hallways	2013	31,128	5,217	7	5,217		18,080	47
48	New Plumbing System-Piping/Shutoff Valves throughout	2013	2,426	62	39	62		168	48
49	Therapy Rm Hallway Modifications-Install Wall/Door to Enclose	2013	14,348	2,405	7	2,405		8,333	49
50	New Exterior Signs	2013	4,590	118	39	118		310	50
51	Project 3077 Plans-Therapy Room Hallway	2013	1,277	33	39	33		84	51
52	New Wall Mural	2013	1,200	80	15	80		210	52
53	New Stone Floor Tile-Nurses Station	2013	3,366	225	15	225		534	53
54	Kamdean Stock Flooring-Room 204	2013	1,055	70	15	70		166	54
55	Remove Concrete and Relocate Light Pole	2013	4,400	113	39	113		268	55
56	3 lite Slider Windows for Rooms 314 & 317	2013	2,485	166	15	166		394	56
57	Concrete Installation-Extend Sidewalk/Front Entrance	2013	3,740	96	39	96		220	57
58	New Windows	2013	2,485	166	15	166		394	58
59	Shower Tile-Small Shower Room-200 Wing	2013	3,368	225	15	225		534	59
60	Hardwood Flooring-Room 206	2013	2,528	169	15	169		359	60
61	Tile and Cove Base-Room 208	2013	2,528	169	15	169		359	61
62	Tile and Cove Base-Room 210/212	2013	2,717	181	15	181		385	62
63	Tile and Cove Base-Resident Rooms	2014	10,539		15	702	702	1,053	63
64	Window Replacement - 91 new windows	2014	62,710		15	4,180	4,180	6,270	64
65	Thru Wall Air Conditioner Units	2014	6,728		15	448	448	672	65
66	Replace siding	2014	8,249		15	550	550	825	66
67	Repave parking lot	2014	70,000		15	4,667	4,667	7,000	67
68	Rewire and repair outside sign and rewire lightpole	2014	4,332		15	289	289	433	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,959,430	\$ 98,404		\$ 109,999	\$ 11,595	\$ 2,540,565	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,959,430	\$ 98,404		\$ 109,999	\$ 11,595	\$ 2,540,565	1
2	Tile and Cove Base - 6 Resident Rooms	2014	5,204		15	347	347	521	2
3	Install new humidifier on furnace	2014	3,350		15	223	223	335	3
4	Tile and Cove Base - SS Office, Bus. Office, Med Rec Office, Utility Closets, 2 Bathrooms & Remaining Resident Rms	2015	22,406		15	747	747	747	4
5									5
6	Seal Parking Lot	2015	2,900		15	97	97	97	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	TOTAL (lines 1 thru 33)		\$ 2,993,290	\$ 98,404		\$ 111,413	\$ 13,009	\$ 2,542,265	34

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 Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,175,258	\$ 80,818	\$ 80,818	\$	3-15 yrs	\$ 974,874	71
72	Current Year Purchases	7,367	1,228	1,228		3 yrs	1,228	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co			6	6			74
75	TOTALS	\$ 1,182,625	\$ 82,046	\$ 82,052	\$ 6		\$ 976,102	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility Van	VAN	2007	\$ 45,133	\$	\$	\$	5	\$ 45,133	76
77	Patient Care	2013 Dodge Grand Caravan	2013	47,384	9,475	9,475		5	23,688	77
78										78
79										79
80	TOTALS			\$ 92,517	\$ 9,475	\$ 9,475	\$		\$ 68,821	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,302,547	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,925	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 202,940	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,015	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,587,188	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Allocated from Management Company

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>7,286</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>7,286</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 28,555 Description: Nursing Equipment - \$16,824; Dietary Equipment - \$1,056; Admin Equipment - \$10,675

(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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/15 Ending: 12/31/15
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>It is the policy of this facility to only hire certified nurses aides. 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	10A(3)	hrs	\$	2,589	\$ 137,283	\$	2,589	\$ 137,283	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,592	61,590		1,592	61,590	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		3,069	165,036	604	3,069	165,640	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				131,294		131,294	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			\$	7,250	\$ 363,909	\$ 131,898	7,250	\$ 495,807	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning: 1/1/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 81,077	\$ 221,177	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>27</u>)	801,606	801,606	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,084	4,084	6
7	Other Prepaid Expenses	15,790	20,349	7
8	Accounts Receivable (owners or related parties)	1,667,255	3,338,878	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,569,812	\$ 4,386,094	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		728,707	15
16	Equipment, at Historical Cost		1,275,142	16
17	Accumulated Depreciation (book methods)		(3,587,188)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		242,299	21
22	Other Long-Term Assets (spec <u>Loan Costs</u>)		167,251	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,124,909	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,569,812	\$ 5,511,003	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 273,750	\$ 273,750	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	8,490	94,498	29
30	Accrued Salaries Payable	189,168	189,168	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,892	64,892	32
33	Accrued Interest Payable	2,963	11,252	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Provider Taxes</u>	63,112	63,112	36
37	<u>Due to IDPA</u>	115,704	115,704	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 718,079	\$ 812,376	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	16,460	16,460	39
40	Mortgage Payable		2,639,038	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)	\$ 16,460	\$ 2,655,498	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 734,539	\$ 3,467,874	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,835,273	\$ 2,043,129	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,569,812	\$ 5,511,003	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,065,168	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,065,168	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(229,895)	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)	\$ (229,895)	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)	\$ 1,835,273	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,594,296	1
2	Discounts and Allowances for all Levels	(430,911)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,163,385	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	615,313	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 615,313	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	99,032	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	66,394	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 165,426	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	301	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 301	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bad Debt Recoveries \$43,962; Misc \$1,822	45,784	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45,784	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,990,209	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	902,467	31
32	Health Care	2,072,968	32
33	General Administration	1,240,070	33
B. Capital Expense			
34	Ownership	417,972	34
C. Ancillary Expense			
35	Special Cost Centers	407,745	35
36	Provider Participation Fee	178,882	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,220,104	40
41	Income before Income Taxes (line 30 minus line 40)**	(229,895)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (229,895)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,457,530	44
45	Private Pay - Net Inpatient Revenue	1,785,658	45
46	Medicare - Net Inpatient Revenue	554,225	46
47	Other-(specify) <u>Insurance</u>	223,375	47
48	Other-(specify) <u>VA</u>	142,597	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,163,385	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	1,796	2,080	\$ 86,630	\$ 41.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,624	12,517	322,329	25.75	3
4	Licensed Practical Nurses	15,520	17,064	362,913	21.27	4
5	CNAs & Orderlies	44,463	47,816	614,165	12.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,527	1,655	24,881	15.03	9
10	Activity Assistants	2,274	2,478	21,723	8.77	10
11	Social Service Workers	1,880	2,080	45,721	21.98	11
12	Dietician					12
13	Food Service Supervisor	1,816	2,080	42,812	20.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,272	16,296	170,220	10.45	15
16	Dishwashers					16
17	Maintenance Workers	3,650	4,108	70,117	17.07	17
18	Housekeepers	10,515	11,511	121,992	10.60	18
19	Laundry	5,220	5,453	64,824	11.89	19
20	Administrator	1,776	2,080	101,724	48.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,900	6,583	181,657	27.59	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) <u>See Sch 20A</u>	3,840	4,385	95,557	21.79	33
34	TOTAL (lines 1 - 33)	127,073	138,186	\$ 2,327,265 *	\$ 16.84	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	\$ 14,666	L1, C3	35
36	Medical Director	96	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,752	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	200	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	496	\$ 32,618		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Farmington Country Manor

Period Beginning 1/1/15
Period End 12/31/15

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	1,864	2,080	57,681	27.73
Central Supply	1,976	2,305	37,876	16.43
TOTAL	<u>3,840</u>	<u>4,385</u>	<u>95,557</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Baker	Administrator	0	\$ 101,724	Workers' Compensation Insurance	\$ 68,617	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	30,589	Advertising: Employee Recruitment	1,911	
				FICA Taxes	168,731	Health Care Worker Background Check		
				Employee Health Insurance	65,509	(Indicate # of checks performed <u>13</u>)	426	
				Employee Meals		Patient Background Checks	118	
				Illinois Municipal Retirement Fund (IMRF)*			1,878	
				Other Employee Benefits	11,892	IHCA Dues	4,094	
						Misc Dues and Subscriptions	2,975	
				Allocated from American Health Corp	39,601	Misc Licenses	1,348	
						Allocated from American Health Corp	327	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,724	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 384,939		\$ 16,939		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 402,889	N/A			Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 402,889				Seminar Expense	1,265
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,265
C. Professional Services				TOTAL				
Vendor/Payee	Type	Amount						
Nerds On Call	Computer Services	\$ 5,990						
American Healthtech	Healthcare Software	6,868						
YoloCare	Website Services	1,045						
Prime Care Technologies	Information Technology	13,986						
Ability Network	Health Info Management	3,620						
Nebo System	Claims Management	140						
Paychex	Payroll Service	16,527						
Johnson & Johnson	Legal	5,857						
Froehling, Weber, Schell	Legal	100						
Templin Healthcare Accounting	Accounting	2,014						
Dominion Due Diligence	PCNA Report	4,300						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 60,447	\$				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
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:

1/1/15

Ending:

12/31/15

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. 4,094 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 3 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,798 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. \$ 178,882
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? Out-Patient Therapy 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. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes
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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- 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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Farmington Country Manor

Period Beginning 1/1/15
Period End 12/31/15

ATTACHED SCHEDULE I

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	4,131
Fuel and miscellaneous supplies	4,800
Allocated from Mgmt Co	761
	<u>9,692</u>

