

Facility Name & ID Number Farmington Country Manor

0045187 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,018	7,877	7,194	27,089	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,018	7,877	7,194	27,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.67%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 2,648

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	229,330	23,289	14,945	267,564		267,564		267,564		1
2	Food Purchase		192,220		192,220		192,220		192,220		2
3	Housekeeping	127,625	21,608		149,233		149,233		149,233		3
4	Laundry	71,541	24,704		96,245		96,245		96,245		4
5	Heat and Other Utilities			82,197	82,197		82,197		82,197		5
6	Maintenance	72,752	123,246	13,832	209,830		209,830	(81,540)	128,290		6
7	Other (specify):*										7
8	TOTAL General Services	501,248	385,067	110,974	997,289		997,289	(81,540)	915,749		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,641,546	100,418	14,728	1,756,692		1,756,692	(1,441)	1,755,251		10
10a	Therapy										10a
11	Activities	61,215	7,842	400	69,457		69,457		69,457		11
12	Social Services	45,852			45,852		45,852		45,852		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,748,613	108,260	27,128	1,884,001		1,884,001	(1,441)	1,882,560		16
	C. General Administration										
17	Administrative	119,905		397,192	517,097		517,097	(231,069)	286,028		17
18	Directors Fees										18
19	Professional Services			61,738	61,738		61,738	16,950	78,688		19
20	Dues, Fees, Subscriptions & Promotions			18,675	18,675		18,675	1,615	20,290		20
21	Clerical & General Office Expenses	179,740	11,532	27,682	218,954		218,954	106,902	325,856		21
22	Employee Benefits & Payroll Taxes			405,675	405,675		405,675	45,589	451,264		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,529	3,529		3,529	(578)	2,951		24
25	Other Admin. Staff Transportation			8,349	8,349		8,349	630	8,979		25
26	Insurance-Prop.Liab.Malpractice			96,239	96,239		96,239		96,239		26
27	Other (specify):*										27
28	TOTAL General Administration	299,645	11,532	1,019,079	1,330,256		1,330,256	(59,961)	1,270,295		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,549,506	504,859	1,157,181	4,211,546		4,211,546	(142,942)	4,068,604		29

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

SEE ACCOUNTANTS' PREPARATION 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:

1/1/2017

Ending:

12/31/2017

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							95,925	95,925		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(287)	(287)		(287)	102,227	101,940		32
33	Real Estate Taxes			66,967	66,967		66,967		66,967		33
34	Rent-Facility & Grounds			192,455	192,455		192,455	(185,227)	7,228		34
35	Rent-Equipment & Vehicles			37,574	37,574		37,574		37,574		35
36	Other (specify):* Mortgage Ins							12,953	12,953		36
37	TOTAL Ownership			296,709	296,709		296,709	25,878	322,587		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		201,447	666,314	867,761		867,761		867,761		39
40	Barber and Beauty Shops			666	666		666		666		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			191,717	191,717		191,717		191,717		42
43	Other (specify):* Disallowed Costs			144,492	144,492		144,492	(144,492)			43
44	TOTAL Special Cost Centers		201,447	1,003,189	1,204,636		1,204,636	(144,492)	1,060,144		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,549,506	706,306	2,457,079	5,712,891		5,712,891	(261,556)	5,451,335		45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

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1/1/2017

Ending:

12/31/2017

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	(9,960)	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	18,802	30		9
10	Interest and Other Investment Income	(412)	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	(50)	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	(6,767)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,176)	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	(205,474)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (215,037)		\$	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)	(46,519)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,519)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (261,556)		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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Farmington Country Manor

ID# 0045187

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallow Out of State Travel	\$ (578)	24	1
2	Disallow Laboratory Expense	(13,868)	43	2
3	Disallow Xray Expense	(5,126)	43	3
4	Capitalize fixed assets for Medicaid basis	(81,540)	6	4
5	Offset Miscellaneous income against expense	(104,362)	43	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	(205,474)		49

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 of Farmington	Farmington	Real Estate entity
		Terrace Oaks	Alabama			
		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Administrative	\$ 397,192	American Health Corpotation	100.00%	\$ 166,123	\$ (231,069)	1
2	V	19 Professional Services		American Health Corpotation	100.00%	11,029	11,029	2
3	V	20 Dues & Subscriptions		American Health Corpotation	100.00%	1,665	1,665	3
4	V	21 Clerical & Gen Office		American Health Corpotation	100.00%	106,902	106,902	4
5	V	22 Emp Benefits & P/R Taxes		American Health Corpotation	100.00%	44,778	44,778	5
6	V	32 Interest Expense		American Health Corpotation	100.00%	260	260	6
7	V	34 Rent - Facility		American Health Corpotation	100.00%	7,228	7,228	7
8	V	19 Professional Services		American Health Corpotation	100.00%	12,688	12,688	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 397,192			\$ 350,673	\$ * (46,519)	14

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

SEE ACCOUNTANTS' PREPARATION 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	\$ 7,726	American Health Corpotation	100.00%	\$ 6,285	\$ (1,441)	15
16	V	22 Employee Benefits & PR Taxes		American Health Corpotation	100.00%	811	811	16
17	V	25 Other Admin Staff Transport.		American Health Corpotation	100.00%	630	630	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		\$ 7,726			\$ 7,726	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION 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%	\$ 77,123	\$ 77,123 15
16	V	32 Interest Expense	64	Midwest Health of Farmington	0.00%	102,443	102,379 16
17	V	34 Rent	192,455	Midwest Health of Farmington	0.00%		(192,455) 17
18	V	36 Mortgage Insurance		Midwest Health of Farmington	0.00%	12,953	12,953 18
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 192,519			\$ 192,519	\$ * 39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	355,106	3	7.50	Mgmt Fee	\$ 94,894	L17, C7	1
2	Gary Stein	Vice President	Administrative	0.00	217,224	8	20.00	Mgmt Fee	58,049	L17, C7	2
3	Jodi Stein	Admin Asst	Administrative	0.00	49,320	1	2.50	Mgmt Fee	13,180	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	\$ 166,123		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' PREPARATION REPORT

Farmington Country Manor

Period Beginning **1/1/2017**
Period End **12/31/2017**

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	92,173	75,351	103,228	94,894	84,354	450,000
Gary Stein	56,384	46,093	63,147	58,049	51,601	275,273
Jodi Stein	12,802	10,465	14,337	13,180	11,716	62,500
	161,358	131,910	180,712	166,123	147,670	787,773

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	128,459	5	\$ 787,773	\$ 787,773	27,089	\$ 166,123	1
2	19	Professional Services	Resident Days	128,459	5	52,299		27,089	11,029	2
3	20	Dues & Subscriptions	Resident Days	128,459	5	7,894		27,089	1,665	3
4	21	Clerical & Gen Office	Resident Days	128,459	5	506,942	381,995	27,089	106,902	4
5	22	Emp Benefits & P/R Taxes	Resident Days	128,459	5	212,343		27,089	44,778	5
6	32	Interest Expense	Resident Days	128,459	5	1,232		27,089	260	6
7	34	Rent - Facility	Resident Days	128,459	5	34,277		27,089	7,228	7
8	19	Professional Services	Direct Allocation	123,389	5	123,389		12,688	12,688	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					\$ 1,726,149	\$ 1,169,768		\$ 350,673	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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	10	Nursing and Medical Records	Direct Cost	5	\$ 125,708	\$ 125,708	6,285	\$ 6,285	1
2	22	Employee Benefits & PR Taxes	Direct Cost	5	16,218		811	811	2
3	25	Other Admin Staff Transport.	Direct Cost	5	12,593		630	630	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				\$ 154,519	\$ 125,708		\$ 7,726	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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		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	BERKADIA COMM MORT		X	LAND, BUILDING, EQUIP	\$31,452.00		\$ 3,017,500	\$ 2,549,837	03/01/2029	6.1500	\$ 94,571	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	BANK OF FARMINGTON		X	Vehicle	\$773.00	10/25/13	42,464	7,605	11/1/18	3.5680	(287)	6						
7												7						
8												8						
9	TOTAL Facility Related				\$32,225.00		\$ 3,059,964	\$ 2,557,442			\$ 94,284	9						
B. Non-Facility Related*																		
10											Amortization of Loan Costs	7,872	10					
11											Interest Income offset	(476)	11					
12											Allocated from Home Office	260	12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$ 7,656	14						
15	TOTALS (line 9+line14)						\$ 3,059,964	\$ 2,557,442			\$ 101,940	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,953 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' PREPARATION REPORT

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

(See instructions.)

2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-04-12-300-013</u>	<u>LAND & BUILDING</u>	\$ <u>66,490.06</u>	\$ <u>66,490.06</u>
2. <u>05-04-12-300-002</u>	<u>LAND & BUILDING</u>	\$ <u>749.78</u>	\$ <u>749.78</u>
3. <u>05-04-12-300-017</u>	<u>LAND & BUILDING</u>	\$ <u>25.34</u>	\$ <u>25.34</u>
4. <u>05-04-12-300-016</u>	<u>LAND & BUILDING</u>	\$ <u>213.28</u>	\$ <u>213.28</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>67,478.46</u></u>	\$ <u><u>67,478.46</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

1/1/2017 Ending:

12/31/2017

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? [X] (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? [X] (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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Facility, 31621, \$34,115. Row 2: (blank), (blank), (blank). Row 3: TOTALS, \$34,115.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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		30		\$	\$ 2,264,583	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	1,298	(176)	50,953	10
11	1989 Additions		1989		36,365		VARIOUS			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		10,485	20
21	Paving Parking Lot		2003		41,839		15			41,839	21
22	Parking Lot		2006		4,890	125	39	125		1,401	22
23	Paving /Blacktopping		2007		4,250	109	39	109		1,176	23
24	Roof		2008		41,366	2,759	15	2,759		26,208	24
25											25
26	Venting		2009		22,548	578	39	578		4,841	26
27	Blinds And Window Treatments		2009		5,132	132	39	132		1,061	27
28	Dining Room Floor		2009		19,295	495	39	495		3,981	28
29	Venting Materials		2009		1,582	41	39	41		330	29
30	Leasehold Improvement		2010		1,122	82	7	82		1,122	30
31	Nurse Call Station		2010		4,600	307	15	307		2,302	31
32	Nurse Call Station		2010		21,526	1,436	15	1,436		10,769	32
33	Carpet		2010		1,927	139	7	139		1,927	33
34											34
35	Nursing Hallway - Floor Tiles		2011		1,319	34	39	34		234	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' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$	\$ 1,386	37
38	Outside - Concrete Installation, Fencing, Sign	2012	11,473	294	39	294		1,630	38
39	Therapy Room Flooring	2012	3,494	90	39	90		491	39
40	Architect Fees For Therapy Room Hallway	2012	1,954	50	39	50		252	40
41	Shower Room Upgrade (200-300 Wing) Gutted and installed	2012	25,250	647	39	647		3,262	41
42	flooring, tile, drywall, cabinets, tub, lighting								42
43	Architect Fees-Therapy Room Hallway	2013	1,338	34	39	34		166	43
44	Sprinkler System-200 Wing	2013	8,914	229	39	229		1,116	44
45	New Plumbing System-Piping/Shutoff Valves throughout	2013	11,203	287	39	287		1,376	45
46	New Plumbing System-Piping/Shutoff Valves throughout	2013	4,002	103	39	103		493	46
47	New Hardwood Flooring-Hallways	2013	31,128	2,761	7	4,447	1,686	26,253	47
48	New Plumbing System-Piping/Shutoff Valves throughout	2013	2,426	62	39	62		292	48
49	Therapy Rm Hallway Modifications-Install Wall/Door to Enclose	2013	14,348	1,273	7	2,049	776	12,099	49
50	New Exterior Signs	2013	4,590	118	39	118		546	50
51	Project 3077 Plans-Therapy Room Hallway	2013	1,277	33	39	33		150	51
52	New Wall Mural	2013	1,200	80	15	80		370	52
53	New Stone Floor Tile-Nurses Station	2013	3,366	225	15	225		984	53
54	Kamdean Stock Flooring-Room 204	2013	1,055	70	15	70		306	54
55	Remove Concrete and Relocate Light Pole	2013	4,400	113	39	113		494	55
56	3 lite Slider Windows for Rooms 314 & 317	2013	2,485	166	15	166		726	56
57	Concrete Installation-Extend Sidewalk/Front Entrance	2013	3,740	96	39	96		412	57
58	New Windows	2013	2,485	166	15	166		726	58
59	Shower Tile-Small Shower Room-200 Wing	2013	3,368	225	15	225		984	59
60	Hardwood Flooring-Room 206	2013	2,528	169	15	169		697	60
61	Tile and Cove Base-Room 208	2013	2,528	169	15	169		697	61
62	Tile and Cove Base-Room 210/212	2013	2,717	181	15	181		747	62
63	Tile and Cove Base-Resident Rooms	2014	10,539		15	702	702	2,457	63
64	Window Replacement - 91 new windows	2014	62,710		15	4,180	4,180	14,630	64
65	Thru Wall Air Conditioner Units	2014	6,728		15	448	448	1,568	65
66	Replace siding	2014	8,249		15	550	550	1,925	66
67	Repave parking lot	2014	70,000		15	4,667	4,667	16,334	67
68	Rewire and repair outside sign and rewire lightpole	2014	4,332		15	289	289	1,011	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,959,430	\$ 16,325		\$ 29,447	\$ 13,122	\$ 2,637,826	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	
1	Totals from Page 12A, Carried Forward		\$ 2,959,430	\$ 16,325		\$ 29,447	\$ 13,122	\$ 2,637,826	1
2	Tile and Cove Base - 6 Resident Rooms	2014	5,204		15	347	347	1,215	2
3	Install new humidifier on furnace	2014	3,350		15	223	223	781	3
4	Tile and Cove Base - SS Office, Bus. Office, Med Rec Office, Utility Closets, 2 Bathrooms & Remaining Resident Rms	2015	22,406		15	1,494	1,494	3,735	4
5	Seal Parking Lot	2015	2,900		15	193	193	483	6
6	6 Thru-Wall Air Conditioning Units	2016	3,991		15	266	266	399	7
7	Woodplank Floor Tile - Activity Rm and Breakroom	2016	2,724		15	182	182	273	8
8	Draperies and Cubicle Curtains - Resident Rooms	2017	33,821		15	1,127	1,127	1,127	9
9	Install On Demand Water Heater	2017	3,835		15	128	128	128	10
10	Front Office-New Carpeting, Window Treatments & Painting	2017	5,544		15	185	185	185	11
11	Metal Shed for Motor Storage	2017	3,391		15	113	113	113	12
12	Seal Parking Lot	2017	3,250		15	108	108	108	13
13	New Siding - Portion of Siding on Front & Back of Building	2017	8,956		15	299	299	299	14
14	Repair and Replace Roof on Gazebo	2017	4,800		15	160	160	160	15
15	Replace Doors to Generator Room and Small Garage	2017	2,550		15	85	85	85	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	TOTAL (lines 1 thru 33)		\$ 3,066,152	\$ 16,325		\$ 34,357	\$ 18,032	\$ 2,646,917	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$ 1,194,776	\$ 50,959	\$ 50,959	\$	3-15 yrs	\$ 1,092,179	71
72	Current Year Purchases	20,493	364	1,134	770	7-10 yrs	1,134	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,215,269	\$ 51,323	\$ 52,093	\$ 770		\$ 1,093,313	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	42,638	77
78										78
79										79
80	TOTALS			\$ 92,517	\$ 9,475	\$ 9,475	\$		\$ 87,771	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)	\$ 4,408,053	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,925	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,802	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,828,001	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' PREPARATION 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>7,228</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>7,228</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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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: \$ 37,574 Description: Nursing Equipment - \$26,442; Dietary Equipment - \$994; Admin Equipment - \$10,138

(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' PREPARATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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' PREPARATION 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	39(3)	hrs	\$	5,486	\$ 286,240	\$	5,486	\$ 286,240	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,906	66,140		1,906	66,140	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		7,095	313,934	520	7,095	314,454	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 prescripts				200,927		200,927	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			\$	14,487	\$ 666,314	\$ 201,447	14,487	\$ 867,761	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' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(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	\$ 188,851	\$ 287,791	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27)	503,140	503,140	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,559	6,559	6
7	Other Prepaid Expenses	1,984	6,252	7
8	Accounts Receivable (owners or related parties)	3,380,315	5,107,730	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,080,849	\$ 5,911,472	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		801,569	15
16	Equipment, at Historical Cost		1,307,786	16
17	Accumulated Depreciation (book methods)		(3,828,001)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		259,403	21
22	Other Long-Term Assets (spe <u>Loan Costs</u>)		151,507	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 990,962	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,080,849	\$ 6,902,434	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,228	\$ 173,228	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	7,605	100,116	29
30	Accrued Salaries Payable	173,724	173,724	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,852	70,852	32
33	Accrued Interest Payable		7,756	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Provider Taxes</u>	59,803	59,803	36
37	<u>Due to Third Parties</u>	105,430	105,430	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 590,642	\$ 690,909	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,457,326	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)	\$	\$ 2,457,326	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 590,642	\$ 3,148,235	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,490,207	\$ 3,754,199	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,080,849	\$ 6,902,434	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,844,434	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,844,435	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	645,772	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)	\$ 645,772	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)	\$ 3,490,207	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,170,024	1
2	Discounts and Allowances for all Levels	(282,998)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,887,026	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,115,131	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,115,131	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	168,905	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	56,028	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 224,933	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	412	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 412	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	131,161	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 131,161	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,358,663	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	997,289	31
32	Health Care	1,884,001	32
33	General Administration	1,330,256	33
B. Capital Expense			
34	Ownership	296,709	34
C. Ancillary Expense			
35	Special Cost Centers	1,012,919	35
36	Provider Participation Fee	191,717	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,712,891	40
41	Income before Income Taxes (line 30 minus line 40)**	645,772	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 645,772	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,575,062	44
45	Private Pay - Net Inpatient Revenue	1,595,199	45
46	Medicare - Net Inpatient Revenue	806,158	46
47	Other-(specify) <u>Insurance</u>	177,950	47
48	Other-(specify) <u>VA</u>	732,657	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,887,026	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' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	1,852	2,080	\$ 90,634	\$ 43.57	1
2	Assistant Director of Nursing	639	717	25,908	36.13	2
3	Registered Nurses	8,593	8,958	309,260	34.52	3
4	Licensed Practical Nurses	15,976	17,809	416,489	23.39	4
5	CNAs & Orderlies	50,139	54,515	726,630	13.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,080	27,450	13.20	9
10	Activity Assistants	2,556	2,776	33,765	12.16	10
11	Social Service Workers	1,760	2,080	45,852	22.04	11
12	Dietician					12
13	Food Service Supervisor	1,887	2,080	44,662	21.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,283	17,777	184,668	10.39	15
16	Dishwashers					16
17	Maintenance Workers	3,623	4,166	72,752	17.46	17
18	Housekeepers	10,595	11,816	127,625	10.80	18
19	Laundry	6,306	7,010	71,541	10.21	19
20	Administrator	1,799	2,080	119,905	57.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,298	8,087	179,740	22.23	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 C: MDS Coord	1,832	2,080	59,320	28.52	32
33	Other(specify) <u>Central Supply</u>	356	467	13,305	28.49	33
34	TOTAL (lines 1 - 33)	133,454	146,578	\$ 2,549,506 *	\$ 17.39	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	\$ 14,945	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	7,002	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	400	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	496	\$ 34,347		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' PREPARATION 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 Baker	Administrator	0	\$ 119,905	Workers' Compensation Insurance	\$ 48,748	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	24,904	Advertising: Employee Recruitment	1,157	
				FICA Taxes	188,098	Health Care Worker Background Check		
				Employee Health Insurance	136,205	(Indicate # of checks performed 5)	175	
				Employee Meals		Patient Background Checks	124 1,984	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	6,072	
				Other Employee Benefits	8,531	Misc Dues and Subscriptions	4,998	
				Allocated from American Health Corp	44,778	Misc Licenses	259	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,905			Allocated from American Health Corp	1,665	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 397,192			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 397,192	TOTAL (agree to Schedule V, line 22, col.8)	\$ 451,264	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,290	
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
Nerds On Call	Computer Services		\$ 5,141				Out-of-State Travel	\$
American Healthtech	Healthcare Software		8,704					
YoloCare	Website Services		1,412				In-State Travel	
Prime Care Technologies	Information Technology		14,528					
eSolutions	Health Info Management		8,439				Seminar Expense	2,951
Pioneer POS Solution	POS Software		645					
Paychex	Payroll Service		15,799				Entertainment Expense	()
Johnson & Johnson	Legal		6,767					
Hepler Broom	Legal		303					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 61,738	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,951

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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. 6,072 IHCA
- (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? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,618 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. \$ 191,717
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? 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? 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. \$ 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

SEE ACCOUNTANTS' PREPARATION REPORT

Farmington Country Manor

Period Beginning **1/1/2017**
Period End **12/31/2017**

ATTACHED SCHEDULE I

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	3,549
Fuel and miscellaneous supplies	4,800
Allocated from Mgmt Co	630
	<u>8,979</u>