FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0045187

Facility Name: FARMINGTON COUNTRY MANOR, INC.

Address: 701 SOUTH MAIN STREET (Number) FARMINGTON (City) 61531 (Zip Code)

County: FULTON

Telephone Number: (309) 245-2407 **Fax #** (309)245-2420

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROBERT CONNER **Telephone Number:** (610) 832-2059
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) ROBERT CONNOR
(Title) CHIEF FINANCIAL OFFICER

Paid Preparer

(Signed) (Date)
(Print Name and Title) BART MCCURLEY, CPA
(Firm Name & Address) SELF, MAPLES & COPELAND, P.C., 1601 2ND AVENUE EAST, ONEONTA, AL 35121
(Telephone) (205) 625-3472 Fax # (205) 274-0182

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,269	11,120	6,522	28,911	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,269	11,120	6,522	28,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.10%

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

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

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

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

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

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 [X] Date 12/01/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 92 and days of care provided 3,687

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,293	17,452	19,525	234,270		234,270		234,270			1
2	Food Purchase		168,820		168,820		168,820	(321)	168,499			2
3	Housekeeping	119,618	16,821		136,439		136,439		136,439			3
4	Laundry	63,074	23,189		86,263		86,263		86,263			4
5	Heat and Other Utilities			113,650	113,650		113,650		113,650			5
6	Maintenance	63,286	42,323	20,659	126,268		126,268		126,268			6
7	Other (specify):*											7
8	TOTAL General Services	443,271	268,605	153,834	865,710		865,710	(321)	865,389			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,417,184	111,456	14,164	1,542,804		1,542,804		1,542,804			10
10a	Therapy		2,219	430,972	433,191		433,191		433,191			10a
11	Activities	53,938	7,566	438	61,942		61,942		61,942			11
12	Social Services	55,670			55,670		55,670		55,670			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,526,792	121,241	457,574	2,105,607		2,105,607		2,105,607			16
	C. General Administration											
17	Administrative	92,409		354,744	447,153		447,153	(106,957)	340,196			17
18	Directors Fees											18
19	Professional Services			21,682	21,682		21,682	12,070	33,752			19
20	Dues, Fees, Subscriptions & Promotions			33,737	33,737		33,737	(26,182)	7,555			20
21	Clerical & General Office Expenses	175,637	13,557	131,792	320,986		320,986	(82,042)	238,944			21
22	Employee Benefits & Payroll Taxes			438,022	438,022		438,022	42,493	480,515			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,348	1,348		1,348		1,348			24
25	Other Admin. Staff Transportation			12,545	12,545		12,545	(12,545)				25
26	Insurance-Prop.Liab.Malpractice			41,514	41,514		41,514		41,514			26
27	Other (specify):*											27
28	TOTAL General Administration	268,046	13,557	1,035,384	1,316,987		1,316,987	(173,163)	1,143,824			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,238,109	403,403	1,646,792	4,288,304		4,288,304	(173,484)	4,114,820			29

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

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, INC. #0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			144,972	144,972		144,972	245	145,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,524	171,524	(12,228)	159,296	(521)	158,775			32
33	Real Estate Taxes			52,264	52,264		52,264		52,264			33
34	Rent-Facility & Grounds							8,016	8,016			34
35	Rent-Equipment & Vehicles			22,942	22,942		22,942		22,942			35
36	Other (specify):* **Mortgage Ins**					12,228	12,228		12,228			36
37	**TOTAL Ownership**			391,702	391,702		391,702	7,740	399,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,190	95,782	107,972		107,972		107,972			39
40	Barber and Beauty Shops			606	606		606		606			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,005	51,005		51,005		51,005			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		12,190	147,393	159,583		159,583		159,583			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,238,109	415,593	2,185,887	4,839,589		4,839,589	(165,744)	4,673,845			45

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,199)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(521)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(321)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,599)	21		24
25	Fund Raising, Advertising and Promotional	(26,182)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (115,822)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,822)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FARMINGTON COUNTRY MANOR, INC.

ID# 0045187

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	UNALLOWABLE TRAVEL	$ (12,545)	25	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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**	(12,545)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(321)	0	0	0	0	0	0	0	0	0	0	(321)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(321)	0	0	0	0	0	0	0	0	0	0	(321)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(106,957)	0	0	0	0	0	0	0	0	0	(106,957)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,070	0	0	0	0	0	0	0	0	0	12,070	19
20	Fees, Subscriptions & Promotions	(26,182)	0	0	0	0	0	0	0	0	0	0	(26,182)	20
21	Clerical & General Office Expenses	(88,798)	6,756	0	0	0	0	0	0	0	0	0	(82,042)	21
22	Employee Benefits & Payroll Taxes	0	42,493	0	0	0	0	0	0	0	0	0	42,493	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(12,545)	0	0	0	0	0	0	0	0	0	0	(12,545)	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**	(127,525)	(45,638)	0	0	0	0	0	0	0	0	0	(173,163)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(127,846)	(45,638)	0	0	0	0	0	0	0	0	0	(173,484)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	245	0	0	0	0	0	0	0	0	0	245	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(521)	0	0	0	0	0	0	0	0	0	0	(521)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,016	0	0	0	0	0	0	0	0	0	8,016	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(521)	8,261	0	0	0	0	0	0	0	0	0	7,740	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,367)	(37,377)	0	0	0	0	0	0	0	0	0	(165,744)	45

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 CORPORATION	100	OAK TRACE	ALABAMA			
AMERICAN HEALTH CORPORATION	100	TERRACE OAKS	ALABAMA			
AMERICAN HEALTH CORPORATION	100	COLONIAL HAVEN	ALABAMA			
AMERICAN HEALTH CORPORATION	100	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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 19,525	AMERICAN HEALTH CORPORATION	100.00%	$ 19,525	$	1
2	V	17	ADMINISTRATIVE	354,744	AMERICAN HEALTH CORPORATION	100.00%	247,787	(106,957)	2
3	V	19	PROFESSIONAL SERVICES		AMERICAN HEALTH CORPORATION	100.00%	12,070	12,070	3
4	V	21	CLERICAL & GEN OFFICE		AMERICAN HEALTH CORPORATION	100.00%	6,756	6,756	4
5	V	22	EMP BENEFITS & P/R TAXES		AMERICAN HEALTH CORPORATION	100.00%	42,493	42,493	5
6	V	34	RENT - FACILITY		AMERICAN HEALTH CORPORATION	100.00%	8,016	8,016	6
7	V	30	DEPRECIATION		AMERICAN HEALTH CORPORATION	100.00%	245	245	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 374,269			$ 336,892	$ * (37,377)	14

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STANLEY STEIN	CEO	Administrative	23.89		10	25.00	Mgmt Fee	$ 79,964	17-8	1
2	GARY STEIN	VICE PRESIDENT	Administrative	0.00		10	25.00	Mgmt Fee	41,524	17-8	2
3	JODI STEIN	ADMIN ASST	Administrative	0.00		10	25.00	Mgmt Fee	11,423	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 132,911		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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] 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 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	17	ADMINISTRATIVE	DAYS	126,542	4	$ 1,084,550	$ 855,596	28,911	$ 247,787	1
2	19	PROFESSIONAL SERVICES	DAYS	126,542	4	52,829		28,911	12,070	2
3	21	CLERICAL & GEN OFFICE	DAYS	126,542	4	29,570		28,911	6,756	3
4	22	EMP BEN & P/R TAXES	DAYS	126,542	4	185,991		28,911	42,493	4
5	34	RENT - FACILITY	DAYS	126,542	4	35,084		28,911	8,016	5
6	30	DEPRECIATION	DAYS	126,542	4	1,074		28,911	245	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,389,098	$ 855,596		$ 317,367	25

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BERKADIA COMM MORT		X	LAND, BUILDING, EQUIP	$31,452.00		$ 3,017,500	$ 2,427,700	03/01/2029	6.1500	$ 158,319	1
2	BANK OF FARMINGTON		X	EQUIPMENT	$698.21	2007	45,133	9,344		4.0000	977	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,150.21		$ 3,062,633	$ 2,437,044			$ 159,296	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,062,633	$ 2,437,044			$ 159,296	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 12,228 **Line #** 32-3

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

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 50,509	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.)		$ 51,386	2
3. Under or (over) accrual (line 2 minus line 1).		$ 877	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,386	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.		$ 52,263	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	53,004	8
2007	53,004	9
2008	47,780	10
2009	50,298	11
2010	50,509	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FARMINGTON COUNTRY MANOR, INC. COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0045187

CONTACT PERSON REGARDING THIS REPORT ROBERT CONNOR, 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-04-12-300-013	LAND & BUILDING	$ 50,503.84	$ 50,503.84
2.	05-04-12-300-002	LAND & BUILDING	$ 701.88	$ 701.88
3.	05-04-12-300-017	LAND & BUILDING	$ 18.56	$ 18.56
4.	05-04-12-300-016	LAND & BUILDING	$ 161.96	$ 161.96
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,386.24	$ 51,386.24

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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).

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING FACILITY		7/28/1986	$ 34,115	1
2					2
3	TOTALS			$ 34,115	3

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1986		$ 2,264,583	$ 75,486	30	$ 75,486	$	$ 1,925,983	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1987 ADDITIONS			1987	2,769	110	25	110		2,720	9
10	1988 ADDITIONS			1988	52,387	1,674	VARIOUS	1,674		42,018	10
11	1989 ADDITIONS			1989	35,606	144	VARIOUS	144		35,247	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	16,921		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		6,147	20
21	PAVING PARKING LOT			2003	41,839	2,791	15	2,791		28,301	21
22	PARKING LOT			2006	4,890	125	39	125		651	22
23	PAVING /BLACKTOPPING			2007	4,250	109	39	109		522	23
24	ROOF			2008	41,366	2,759	15	2,759		9,654	24
25											25
26	VENTING			2009	22,548	578	39	578		1,373	26
27	BLINDS AND WINDOW TREATMENTS			2009	5,132	132	39	132		269	27
28	DINING ROOM FLOOR			2009	19,295	495	39	495		1,011	28
29	VENTING MATERIALS			2009	1,582	41	39	41		84	29
30	LEASEHOLD IMPROVEMENT			2010	1,122	160	7	160		240	30
31	NURSE CALL STATION			2010	4,600	307	15	307		460	31
32	NURSE CALL STATION			2010	21,526	1,436	15	1,436		2,153	32
33	CARPET			2010	1,927	275	7	275		413	33
34											34
35	FLOOR TILES			2011	1,319	30	39	30		30	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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,635,849	$ 87,375		$ 87,375	$	$ 2,138,176	70

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 754,983	$ 44,662	$ 44,662	$		$ 653,560	71
72	Current Year Purchases	39,921	3,908	3,908			3,908	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 794,904	$ 48,570	$ 48,570	$		$ 657,468	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	$ 9,027	$ 9,027	$	5	$ 40,621	76
77										77
78										78
79										79
80	TOTALS			$ 45,133	$ 9,027	$ 9,027	$		$ 40,621	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,510,001	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 144,972	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,972	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,836,265	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.

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 22,942 Description: NURSING EQUIPMENT - $13308, DIETARY EQUIPMENT - $773, ADMIN EQUIPMENT - $8861
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$	1,095	$ 156,205	$	1,095	$ 156,205	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,514	79,517		1,514	79,517	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,396	192,300	2,219	1,396	194,519	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				80,435		80,435	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39					12,190		12,190	12
13	Other (specify): RADIOLOGY	39					4,054		4,054	13
14	TOTAL			$	4,005	$ 428,022	$ 98,898	4,005	$ 526,920	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.

STATE OF ILLINOIS

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 195,169	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27)	613,128		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,461		6
7	Other Prepaid Expenses	3,424		7
8	Accounts Receivable (owners or related parties)	3,085,525		8
9	Other(specify): MCARE BAD DEBT	(1,485)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,898,222	$	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	371,267		15
16	Equipment, at Historical Cost	838,915		16
17	Accumulated Depreciation (book methods)	(2,836,265)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	167,877		21
22	Other Long-Term Assets (spe LOAN COST	106,822		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 947,314	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,845,536	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 145,750	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	97,794		29
30	Accrued Salaries Payable	148,646		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,386		32
33	Accrued Interest Payable	157,933		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 601,509	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,384		39
40	Mortgage Payable	2,337,866		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)**	$ 2,339,250	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,940,759	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,904,777	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,845,536	$	48

***(See instructions.)**

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,455,567	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,455,567	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	449,210	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)**	$ 449,210	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)**	$ 1,904,777	24 *

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,747,908	1
2	Discounts and Allowances for all Levels	(411,967)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,335,941	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	623,288	6
7	Oxygen	21,624	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 644,912	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	83,165	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,381	19
20	Radiology and X-Ray		20
21	Other Medical Services	213,879	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 307,425	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	521	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 521	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,288,799	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	865,710	31
32	Health Care	2,105,607	32
33	General Administration	1,316,987	33
	B. Capital Expense		
34	Ownership	391,702	34
	C. Ancillary Expense		
35	Special Cost Centers	108,578	35
36	Provider Participation Fee	51,005	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,839,589	40
41	**Income before Income Taxes (line 30 minus line 40)****	449,210	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 449,210	43

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

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

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

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,800	2,312	$ 75,836	$ 32.80	1
2	Assistant Director of Nursing	1,840	1,888	58,818	31.15	2
3	Registered Nurses	7,054	9,000	239,355	26.60	3
4	Licensed Practical Nurses	16,470	20,987	460,242	21.93	4
5	CNAs & Orderlies	46,925	58,553	554,306	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,735	3,650	33,133	9.08	9
10	Activity Assistants	1,896	2,264	20,805	9.19	10
11	Social Service Workers	2,320	2,861	55,670	19.46	11
12	Dietician					12
13	Food Service Supervisor	1,344	1,757	38,238	21.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,743	11,077	159,055	14.36	15
16	Dishwashers					16
17	Maintenance Workers	9,932	12,483	63,286	5.07	17
18	Housekeepers	3,532	4,076	119,618	29.35	18
19	Laundry	1,792	2,368	63,074	26.64	19
20	Administrator	8,397	11,180	92,409	8.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	7,291	9,181	175,637	19.13	23
24	Clerical					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: Central Supply	1,856	2,304	28,627	12.42	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,927	155,941	$ 2,238,109 *	$ 14.35	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	279	$ 19,525	1-3	35
36	Medical Director	68	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	288	6,363	10-3	38
39	Pharmacist Consultant	63	5,225	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	192	2,950	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	438	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	906	$ 46,501		49

C. CONTRACT NURSES

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

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JENNIFER BAKER	ADMINISTRATOR	0	$ 92,409
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,409

B. Administrative - Other

Description	Amount
AMERICAN HEALTH CORPORATION	$ 354,744
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 354,744

C. Professional Services

Vendor/Payee	Type	Amount
NERDS ON CALL	DATA PROCESSING	$ 7,712
LTC SOLUTIONS	DATA PROCESSING	7,685
DIGITAL COPY SYSTEMS	DATA PROCESSING	656
FROELING, WEBBER, EVANS	LEGAL FEES	1,419
CLAUDON, KOST, BEAL, WALTE	LEGAL FEES	560
SELF, MAPLES, & COPELAND	ACCOUNTING	3,650
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,682

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,313
Unemployment Compensation Insurance	25,216
FICA Taxes	162,571
Employee Health Insurance	120,048
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE ACTIVITIES	16,874
HLTH INS & TAXES FROM CENTRAL OFFIC	42,493
TOTAL (agree to Schedule V, line 22, col.8)	$ 480,515

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 300
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
MARKETING	26,182
IHCA DUES	4,407
OTHER DUES & SUBSCRIPTIONS	2,848
Less: Public Relations Expense	( )
Non-allowable advertising	(26,182)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,555

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
ADMIN TRAVEL	63
Seminar Expense	1,285
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,348

**See instructions.

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FARMINGTON COUNTRY MANOR, INC. # 0045187 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. ILLINOIS HEALTHCARE ASSOC $4407

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 33,248 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 50,378
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? NO Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? 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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.