		FOR BHF USE					

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0045187

Facility Name: Farmington Country Manor

Address: 701 S Main St (Number) Farmington (City) (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 1/1/2018 to 12/31/2018 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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	6,341	9,193	11,785	27,319	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,341	9,193	11,785	27,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.35%

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 [X] 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 [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 3,340

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: 12/31/18 Fiscal Year: 12/31/18

* 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: 1/1/2018 Ending: 12/31/2018

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	225,642	19,532	16,280	261,454		261,454		261,454			1
2	Food Purchase		191,952		191,952		191,952		191,952			2
3	Housekeeping	133,109	22,028		155,137		155,137		155,137			3
4	Laundry	75,087	23,763		98,850		98,850		98,850			4
5	Heat and Other Utilities			90,947	90,947		90,947		90,947			5
6	Maintenance	76,479	40,355	11,455	128,289		128,289		128,289			6
7	Other (specify):*											7
8	**TOTAL General Services**	510,317	297,630	118,682	926,629		926,629		926,629			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,755,906	100,523	15,089	1,871,518		1,871,518	(1,387)	1,870,131			10
10a	Therapy											10a
11	Activities	65,054	7,820	862	73,736		73,736		73,736			11
12	Social Services	45,455			45,455		45,455		45,455			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,866,415	108,343	27,951	2,002,709		2,002,709	(1,387)	2,001,322			16
	C. General Administration											
17	Administrative	118,517		417,437	535,954		535,954	(221,035)	314,919			17
18	Directors Fees											18
19	Professional Services			63,555	63,555		63,555	26,854	90,409			19
20	Dues, Fees, Subscriptions & Promotions			11,419	11,419		11,419	(1,935)	9,484			20
21	Clerical & General Office Expenses	223,506	9,793	29,610	262,909		262,909	97,384	360,293			21
22	Employee Benefits & Payroll Taxes			433,025	433,025		433,025	45,830	478,855			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,056	3,056		3,056	(521)	2,535			24
25	Other Admin. Staff Transportation			10,907	10,907		10,907	603	11,510			25
26	Insurance-Prop.Liab.Malpractice			125,780	125,780		125,780		125,780			26
27	Other (specify):*											27
28	**TOTAL General Administration**	342,023	9,793	1,094,789	1,446,605		1,446,605	(52,820)	1,393,785			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,718,755	415,766	1,241,422	4,375,943		4,375,943	(54,207)	4,321,736			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: 1/1/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							88,784	88,784			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128	128		128	91,802	91,930			32
33	Real Estate Taxes			67,649	67,649		67,649		67,649			33
34	Rent-Facility & Grounds			179,614	179,614		179,614	(170,804)	8,810			34
35	Rent-Equipment & Vehicles			21,342	21,342		21,342		21,342			35
36	Other (specify):* **Mortgage Ins**							20,179	20,179			36
37	**TOTAL Ownership**			268,733	268,733		268,733	29,961	298,694			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,485	616,302	836,787		836,787		836,787			39
40	Barber and Beauty Shops			860	860		860		860			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,948	193,948		193,948		193,948			42
43	Other (specify):* **Disallowed Costs**			237,478	237,478		237,478	(237,478)				43
44	**TOTAL Special Cost Centers**		220,485	1,048,588	1,269,073		1,269,073	(237,478)	1,031,595			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,718,755	636,251	2,558,743	5,913,749		5,913,749	(261,724)	5,652,025			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 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(10,774)	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	20,731	30		9
10	Interest and Other Investment Income	(1,368)	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	(1,935)	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	56	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(171,645)	43		24
25	Fund Raising, Advertising and Promotional	(13,128)	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	(65,896)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (243,959)		$	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)	(17,765)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,765)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (261,724)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Farmington Country Manor
ID# 0045187
Report Period Beginning: 1/1/2018
Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Out of State Travel	$ (521)	24	1
2	Disallow Laboratory Expense	(9,144)	43	2
3	Disallow Xray Expense	(3,962)	43	3
4	Offset Miscellaneous income against expense	(28,825)	43	4
5	Disallow Marketing Director wages	(23,444)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(65,896)		49

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Corportation	100	Oak Trace	Alabama	Midwest Health	Farmington	Real Estate entity
		Terrace Oaks	Alabama	of Farmington		
		Colonial Haven	Alabama			
		Rainbow of New Jersey, Inc.	New Jersey			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	17	Administrative	$ 417,437	American Health Corportation	100.00%	$ 196,402	$ (221,035)	1
2	V	19	Professional Services		American Health Corportation	100.00%	26,798	26,798	2
3	V	21	Clerical & Gen Office		American Health Corportation	100.00%	120,828	120,828	3
4	V	22	Emp Benefits & P/R Taxes		American Health Corportation	100.00%	45,046	45,046	4
5	V	32	Interest Expense		American Health Corportation	100.00%	1,788	1,788	5
6	V	34	Rent - Facility		American Health Corportation	100.00%	8,810	8,810	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 417,437			$ 399,672	$ * (17,765)	14

* 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: 1/1/2018 Ending: 12/31/2018

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. [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)	
15	V	10	Nursing and Medical Records	$ 7,740	American Health Corportation	100.00%	$ 6,353	$ (1,387)	15
16	V	22	Employee Benefits & PR Taxes		American Health Corportation	100.00%	784	784	16
17	V	25	Other Admin Staff Transport.		American Health Corportation	100.00%	603	603	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			$ 7,740			$ 7,740	$ *	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: 1/1/2018 Ending: 12/31/2018

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. [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)	
15	V	30	Depreciation	$	Midwest Health of Farmington	0.00%	$ 68,053	$ 68,053	15
16	V	32	Interest Expense	60	Midwest Health of Farmington	0.00%	91,442	91,382	16
17	V	34	Rent	179,614	Midwest Health of Farmington	0.00%		(179,614)	17
18	V	36	Mortgage Insurance		Midwest Health of Farmington	0.00%	20,179	20,179	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			$ 179,674			$ 179,674	$ *	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: 1/1/2018 Ending: 12/31/2018

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	459,276	4	10.00	Mgmt Fee	$ 120,724	L17, C7	1
2	Gary Stein	Vice President	Administrative	0.00	231,381	8	20.00	Mgmt Fee	60,819	L17, C7	2
3	Jodi Stein	Admin Asst	Administrative	0.00	49,491	0	0.00	Mgmt Fee	13,009	L17, C7	3
4	Eric Stein	Executive VP	Administrative	0.00	7,039	8	20.00	Mgmt Fee	1,850	L17, C7	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	$ 196,402		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

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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: 200 Barr Harbor Drive, Suite 400
City / State / Zip Code: West Conshohocken, PA 19428
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	Resident Days	131,251	5	$ 943,589	$ 943,589	27,319	$ 196,402	1
2	19	Professional Services	Resident Days	131,251	5	128,750		27,319	26,798	2
3	21	Clerical & Gen Office	Resident Days	131,251	5	580,506	451,523	27,319	120,828	3
4	22	Emp Benefits & P/R Taxes	Resident Days	131,251	5	216,417		27,319	45,046	4
5	32	Interest Expense	Resident Days	131,251	5	8,588		27,319	1,788	5
6	34	Rent - Facility	Resident Days	131,251	5	42,327		27,319	8,810	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					$ 1,920,177	$ 1,395,112		$ 399,672	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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: 200 Barr Harbor Drive, Suite 400
City / State / Zip Code: West Conshohocken, PA 19428
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	10	Nursing and Medical Records	Direct Cost	127,055	5	$ 127,055	$ 127,055	6,353	$ 6,353	1
2	22	Employee Benefits & PR Taxes	Direct Cost	15,689	5	15,689		784	784	2
3	25	Other Admin Staff Transport.	Direct Cost	12,058	5	12,058		603	603	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					$ 154,802	$ 127,055		$ 7,740	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,457,326	03/01/2029	6.1500	$ 83,570	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK OF FARMINGTON		X	Vehicle	$773.00	10/25/13	42,464		11/1/18	3.5680	128	6
7												7
8												8
9	TOTAL Facility Related				$32,225.00		$ 3,059,964	$ 2,457,326			$ 83,698	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			7,872	10
11								Interest Income offset			(1,428)	11
12								Allocated from Home Office			1,788	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,232	14
15	TOTALS (line 9+line14)						$ 3,059,964	$ 2,457,326			$ 91,930	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 20,179 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.)

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 70,852	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.)	2017	$ 68,653	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,199)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 69,848	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.		$ 67,649	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	53,868	8
	2014	64,892	9
	2015	67,965	10
	2016	67,479	11
	2017	68,653	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-04-12-300-013	LAND & BUILDING	$ 67,647.68	$ 67,647.68
2.	05-04-12-300-002	LAND & BUILDING	$ 762.98	$ 762.98
3.	05-04-12-300-017	LAND & BUILDING	$ 25.94	$ 25.94
4.	05-04-12-300-016	LAND & BUILDING	$ 216.82	$ 216.82
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,653.42	$ 68,653.42

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

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		31621	$ 34,115	1
2					2
3	TOTALS			$ 34,115	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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		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	1,230	VARIOUS		(1,230)	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		11,208	20
21	Paving Parking Lot			2003	41,839		15			41,839	21
22	Parking Lot			2006	4,890	125	39	125		1,526	22
23	Paving /Blacktopping			2007	4,250	109	39	109		1,285	23
24	Roof			2008	41,366	2,759	15	2,759		28,967	24
25											25
26	Venting			2009	22,548	578	39	578		5,419	26
27	Blinds And Window Treatments			2009	5,132	132	39	132		1,193	27
28	Dining Room Floor			2009	19,295	495	39	495		4,476	28
29	Venting Materials			2009	1,582	41	39	41		371	29
30	Leasehold Improvement			2010	1,122		7			1,122	30
31	Nurse Call Station			2010	4,600	307	15	307		2,609	31
32	Nurse Call Station			2010	21,526	1,436	15	1,436		12,205	32
33	Carpet			2010	1,927		7			1,927	33
34											34
35	Nursing Hallway - Floor Tiles			2011	1,319	34	39	34		268	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: 1/1/2018 Ending: 12/31/2018

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	Outside - Seal Coating, Benches, Landscaping Rock	2012	$ 9,754	$ 250	39	$ 250	$	$ 1,636	37
38	Outside - Concrete Installation, Fencing, Sign	2012	11,473	294	39	294		1,924	38
39	Therapy Room Flooring	2012	3,494	90	39	90		581	39
40	Architect Fees For Therapy Room Hallway	2012	1,954	50	39	50		302	40
41	Shower Room Upgrade (200-300 Wing) Gutted and installed	2012	25,250	647	39	647		3,909	41
42	flooring, tile, drywall, cabinets, tub, lighting								42
43	Architect Fees-Therapy Room Hallway	2013	1,338	34	39	34		200	43
44	Sprinkler System-200 Wing	2013	8,914	229	39	229		1,345	44
45	New Plumbing System-Piping/Shutoff Valves throughout	2013	11,203	287	39	287		1,663	45
46	New Plumbing System-Piping/Shutoff Valves throughout	2013	4,002	103	39	103		596	46
47	New Hardwood Flooring-Hallways	2013	31,128	2,761	7	4,447	1,686	30,700	47
48	New Plumbing System-Piping/Shutoff Valves throughout	2013	2,426	62	39	62		354	48
49	Therapy Rm Hallway Modifications-Install Wall/Door to Enclose	2013	14,348	1,273	7	2,049	776	14,148	49
50	New Exterior Signs	2013	4,590	118	39	118		664	50
51	Project 3077 Plans-Therapy Room Hallway	2013	1,277	33	39	33		183	51
52	New Wall Mural	2013	1,200	80	15	80		450	52
53	New Stone Floor Tile-Nurses Station	2013	3,366	225	15	225		1,209	53
54	Kamdean Stock Flooring-Room 204	2013	1,055	70	15	70		376	54
55	Remove Concrete and Relocate Light Pole	2013	4,400	113	39	113		607	55
56	3 lite Slider Windows for Rooms 314 & 317	2013	2,485	166	15	166		892	56
57	Concrete Installation-Extend Sidewalk/Front Entrance	2013	3,740	96	39	96		508	57
58	New Windows	2013	2,485	166	15	166		892	58
59	Shower Tile-Small Shower Room-200 Wing	2013	3,368	225	15	225		1,209	59
60	Hardwood Flooring-Room 206	2013	2,528	169	15	169		866	60
61	Tile and Cove Base-Room 208	2013	2,528	169	15	169		866	61
62	Tile and Cove Base-Room 210/212	2013	2,717	181	15	181		928	62
63	Tile and Cove Base-Resident Rooms	2014	10,539		15	702	702	3,159	63
64	Window Replacement - 91 new windows	2014	62,710		15	4,180	4,180	18,810	64
65	Thru Wall Air Conditioner Units	2014	6,728		15	448	448	2,016	65
66	Replace siding	2014	8,249		15	550	550	2,475	66
67	Repave parking lot	2014	70,000		15	4,667	4,667	21,001	67
68	Rewire and repair outside sign and rewire lightpole	2014	4,332		15	289	289	1,300	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,959,430	$ 15,860		$ 27,928	$ 12,068	$ 2,665,754	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: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,959,430	$ 15,860		$ 27,928	$ 12,068	$ 2,665,754	1
2	Tile and Cove Base - 6 Resident Rooms	2014	5,204		15	347	347	1,562	2
3	Install new humidifier on furnace	2014	3,350		15	223	223	1,004	3
4	Tile and Cove Base - SS Office, Bus. Office, Med Rec Office,	2015	22,406		15	1,494	1,494	5,229	4
5	Utility Closets, 2 Bathrooms & Remaining Resident Rms								5
6	Seal Parking Lot	2015	2,900		15	193	193	676	6
7	6 Thru-Wall Air Conditioning Units	2016	3,991		15	266	266	665	7
8	Woodplank Floor Tile - Activity Rm and Breakroom	2016	2,724		15	182	182	455	8
9	Draperies and Cubicle Curtains - Resident Rooms	2017	33,821		15	2,255	2,255	3,382	9
10	Install On Demand Water Heater	2017	3,835		15	256	256	384	10
11	Front Office-New Carpeting, Window Treatments & Painting	2017	5,544		15	370	370	555	11
12	Metal Shed for Motor Storage	2017	3,391		15	226	226	339	12
13	Seal Parking Lot	2017	3,250		15	217	217	325	13
14	New Siding - Portion of Siding on Front & Back of Building	2017	8,956		15	597	597	896	14
15	Repair and Replace Roof on Gazebo	2017	4,800		15	320	320	480	15
16	Replace Doors to Generator Room and Small Garage	2017	2,550		15	170	170	255	16
17	Install 200 Amp Emergency Panel	2018	14,845	270	39	270		270	17
18	Asphalt Paving - Added New Paved Area	2018	22,620	753	15	753		753	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,103,617	$ 16,883		$ 36,067	$ 19,184	$ 2,682,984	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: 1/1/2018 Ending: 12/31/2018

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	$ 1,215,269	$ 45,322	$ 45,322	$	3-15 yrs	$ 1,138,635	71
72	Current Year Purchases	15,545	1,110	2,649	1,539	7 Yrs	2,649	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,230,814	$ 46,432	$ 47,971	$ 1,539		$ 1,141,284	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	4,738	4,746	8	5	47,384	77
78										78
79										79
80	TOTALS			$ 92,517	$ 4,738	$ 4,746	$ 8		$ 92,517	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)	$ 4,461,063	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,053	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,784	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,731	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,916,785	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

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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:				$ 8,810			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 8,810 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 21,342 Description: Nursing Equipment - $9,897; Dietary Equipment - $1,088; Admin Equipment - $10,357
(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	N/A				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

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	5,195	$ 268,460	$	5,195	$ 268,460	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,835	70,330		1,835	70,330	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		6,227	277,512	225	6,227	277,737	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				220,260		220,260	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			$	13,257	$ 616,302	$ 220,485	13,257	$ 836,787	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: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 87,751	$ 119,507	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27)	581,377	581,377	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,893	5,893	6
7	Other Prepaid Expenses	4,435	8,550	7
8	Accounts Receivable (owners or related parties)	3,766,892	5,464,690	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,446,348	$ 6,180,017	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		839,034	15
16	Equipment, at Historical Cost		1,323,331	16
17	Accumulated Depreciation (book methods)		(3,916,785)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		286,480	21
22	Other Long-Term Assets (specify):		143,634	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 974,392	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,446,348	$ 7,154,409	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 180,495	$ 180,495	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		95,945	29
30	Accrued Salaries Payable	187,240	187,240	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,848	69,848	32
33	Accrued Interest Payable	1,118	8,592	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Taxes	38,196	38,196	36
37	Due to Third Parties	103,768	103,768	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 580,665	$ 684,084	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,361,381	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)**	$	$ 2,361,381	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 580,665	$ 3,045,465	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,865,683	$ 4,108,944	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,446,348	$ 7,154,409	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,490,207	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,490,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	375,476	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)**	$ 375,476	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)**	$ 3,865,683	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,178,524	1
2	Discounts and Allowances for all Levels	(142,376)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,036,148	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,002,158	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,002,158	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	179,276	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	41,450	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 220,726	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,368	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,368	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	28,825	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,825	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,289,225	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	926,629	31
32	Health Care	2,002,709	32
33	General Administration	1,446,605	33
	B. Capital Expense		
34	Ownership	268,733	34
	C. Ancillary Expense		
35	Special Cost Centers	1,075,125	35
36	Provider Participation Fee	193,948	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,913,749	40
41	**Income before Income Taxes (line 30 minus line 40)****	375,476	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 375,476	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,454,844	44
45	Private Pay - Net Inpatient Revenue	1,826,393	45
46	Medicare - Net Inpatient Revenue	937,569	46
47	Other-(specify) Insurance	198,175	47
48	Other-(specify) VA	619,167	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,036,148	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: 1/1/2018 Ending: 12/31/2018

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	1,808	2,080	$ 98,344	$ 47.28	1
2	Assistant Director of Nursing	1,646	2,050	57,471	28.03	2
3	Registered Nurses	8,714	9,193	321,710	35.00	3
4	Licensed Practical Nurses	16,638	18,323	404,083	22.05	4
5	CNAs & Orderlies	59,105	64,810	810,255	12.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,916	2,080	35,757	17.19	9
10	Activity Assistants	2,808	3,073	29,297	9.53	10
11	Social Service Workers	1,720	1,933	45,455	23.52	11
12	Dietician					12
13	Food Service Supervisor	1,770	2,080	47,938	23.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,370	14,643	177,704	12.14	15
16	Dishwashers					16
17	Maintenance Workers	3,671	4,164	76,479	18.37	17
18	Housekeepers	10,221	11,521	133,109	11.55	18
19	Laundry	6,247	6,760	75,087	11.11	19
20	Administrator	1,792	2,080	118,517	56.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,224	9,237	223,506	24.20	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	1,846	2,080	64,043	30.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,496	156,107	$ 2,718,755 *	$ 17.42	34

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	288	$ 16,280	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	7,349	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	862	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	496	$ 36,491		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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

** See instructions.

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Baker	Administrator	0	$ 118,517
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,517

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 417,437
TOTAL (agree to Schedule V, line 17, col. 3)	$ 417,437
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nerds On Call	Computer Services	$ 8,172
American Healthtech	Healthcare Software	8,705
YoloCare	Website Services	1,308
Prime Care Technologies	Information Techology	16,199
eSolutions	Health Info Management	7,619
Misc	Computer Software	505
Paychex	Payroll Service	10,761
Johnson & Johnson	Legal	650
Hepler Broom	Legal	10,375
Refund	Legal	(739)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 63,555

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,149
Unemployment Compensation Insurance	27,174
FICA Taxes	196,527
Employee Health Insurance	154,972
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,203
Allocated from American Health Corp	45,830
TOTAL (agree to Schedule V, line 22, col.8)	$ 478,855

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	160
Health Care Worker Background Check	
(Indicate # of checks performed 5)	200
Patient Background Checks 145	2,320
IHCA Dues	6,072
Misc Dues and Subscriptions	2,408
Misc Licenses	259
Less: Public Relations Expense	(1,935)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,484

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,535
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,535

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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? **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?

(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. $ **26,103** 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. $ **193,948**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Out-Patient Therapy** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **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