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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0050161

Facility Name: Friendship Manor Health Care

Address: 485 S Friendship Dr (Number) Nashville (City) 62263 (Zip Code)

County: Washington

Telephone Number: (618) 327-3041 **Fax #** (618) 327-4001

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2008

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Rhonda Houchens **Telephone Number:** (270) 726-4033
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 01/01/14 to 12/31/2014 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) (Date)
(Print Name and Title) Rhonda Houchens, Client Manager
(Firm Name & Address) Hargis & Associates, LLC, PO Box 263, Russellville, KY 42276
(Telephone) (270) 726-4033 Fax # (270) 726-8069

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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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 N/A

	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	230	Skilled (SNF)	230	83,950	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	230	TOTALS	230	83,950	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	16,327	16,897	4,386	37,610	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,327	16,897	4,386	37,610	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.80%

D. How many bed-hold days during this year were paid by the Department?
4 (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)
None

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 11/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 230 and days of care provided 3,151

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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	278,145	22,470	9,640	310,255		310,255	(1,026)	309,229			1
2	Food Purchase		229,047		229,047		229,047	(2,535)	226,512			2
3	Housekeeping	226,889	23,941		250,830		250,830		250,830			3
4	Laundry	79,658	18,133		97,791		97,791		97,791			4
5	Heat and Other Utilities			197,527	197,527		197,527	(10,735)	186,792			5
6	Maintenance	79,264	1,914	51,212	132,390		132,390	8,807	141,197			6
7	Other (specify):*			25,624	25,624		25,624		25,624			7
8	**TOTAL General Services**	663,956	295,505	284,003	1,243,464		1,243,464	(5,489)	1,237,975			8
	B. Health Care and Programs											
9	Medical Director			9,475	9,475		9,475		9,475			9
10	Nursing and Medical Records	1,776,843	77,984	13,246	1,868,073	13,990	1,882,063	2,205	1,884,268			10
10a	Therapy											10a
11	Activities	69,690	5,324	11,013	86,027		86,027	(2,155)	83,872			11
12	Social Services	94,070	161		94,231	(45,490)	48,741		48,741			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,940,603	83,469	33,734	2,057,806	(31,500)	2,026,306	50	2,026,356			16
	C. General Administration											
17	Administrative	90,759		360,000	450,759		450,759	(162,420)	288,339			17
18	Directors Fees											18
19	Professional Services			66,131	66,131	(13,990)	52,141		52,141			19
20	Dues, Fees, Subscriptions & Promotions			26,170	26,170		26,170	(7,953)	18,217			20
21	Clerical & General Office Expenses	89,921	12,516	37,841	140,278		140,278	43,094	183,372			21
22	Employee Benefits & Payroll Taxes			408,997	408,997		408,997	91,720	500,717			22
23	Inservice Training & Education			3,038	3,038		3,038		3,038			23
24	Travel and Seminar			616	616		616	(4)	612			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,747	85,747		85,747		85,747			26
27	Other (specify):*											27
28	**TOTAL General Administration**	180,680	12,516	988,540	1,181,736	(13,990)	1,167,746	(35,563)	1,132,183			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,785,239	391,490	1,306,277	4,483,006	(45,490)	4,437,516	(41,002)	4,396,514			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 Friendship Manor Health Care #0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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			194,303	194,303		194,303	15,622	209,925			30
31	Amortization of Pre-Op. & Org.			36,933	36,933		36,933	(36,933)				31
32	Interest			228,623	228,623		228,623	(12,838)	215,785			32
33	Real Estate Taxes			85,102	85,102		85,102		85,102			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,357	3,357		3,357		3,357			35
36	Other (specify):*											36
37	**TOTAL Ownership**			548,318	548,318		548,318	(34,149)	514,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,623	2,623		2,623		2,623			38
39	Ancillary Service Centers		74,397	499,323	573,720		573,720		573,720			39
40	Barber and Beauty Shops		237		237		237		237			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			331,478	331,478		331,478		331,478			42
43	Other (specify):*					45,490	45,490	(45,490)				43
44	**TOTAL Special Cost Centers**		74,634	833,424	908,058	45,490	953,548	(45,490)	908,058			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,785,239	466,124	2,688,019	5,939,382		5,939,382	(120,641)	5,818,741			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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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	(2,026)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,622	30		9
10	Interest and Other Investment Income	(12,838)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(509)	02		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	(39)	21		18
19	Entertainment	(265)	21		19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,353)	21		24
25	Fund Raising, Advertising and Promotional	(7,953)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,980)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (106,441)		$	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)	(14,200)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (14,200)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (120,641)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Friendship Manor Health Care

ID# 0050161

Report Period Beginning: 01/01/14

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 8,807	06	1
2	Vending Income	(1,026)	1	2
3	Bank Fees	(1,752)	21	3
4	Flowers	(2,155)	11	4
5	Plant Cable	(10,735)	05	5
6	Amortization	(36,933)	31	6
7	Non-Allowable Seminar	(4)	24	7
8	Marketing Salary	(45,490)	43	8
9	Additional R&M (Computers)	1,103	21	9
10	Additional R&M (Nursing)	2,205	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**	(85,980)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor Health Care **#** 0050161 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/2014

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,026)	0	0	0	0	0	0	0	0	0	0	(1,026)	1
2	Food Purchase	(2,535)	0	0	0	0	0	0	0	0	0	0	(2,535)	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	(10,735)	0	0	0	0	0	0	0	0	0	0	(10,735)	5
6	Maintenance	8,807	0	0	0	0	0	0	0	0	0	0	8,807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,489)	0	0	0	0	0	0	0	0	0	0	(5,489)	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	2,205	0	0	0	0	0	0	0	0	0	0	2,205	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,155)	0	0	0	0	0	0	0	0	0	0	(2,155)	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**	50	0	0	0	0	0	0	0	0	0	0	50	16
	C. General Administration													
17	Administrative	0	(162,420)	0	0	0	0	0	0	0	0	0	(162,420)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,953)	0	0	0	0	0	0	0	0	0	0	(7,953)	20
21	Clerical & General Office Expenses	(13,406)	56,500	0	0	0	0	0	0	0	0	0	43,094	21
22	Employee Benefits & Payroll Taxes	0	91,720	0	0	0	0	0	0	0	0	0	91,720	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4)	0	0	0	0	0	0	0	0	0	0	(4)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,363)	(14,200)	0	0	0	0	0	0	0	0	0	(35,563)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,802)	(14,200)	0	0	0	0	0	0	0	0	0	(41,002)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor Health Care # 0050161 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/2014

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	15,622	0	0	0	0	0	0	0	0	0	0	15,622	30
31	Amortization of Pre-Op. & Org.	(36,933)	0	0	0	0	0	0	0	0	0	0	(36,933)	31
32	Interest	(12,838)	0	0	0	0	0	0	0	0	0	0	(12,838)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(34,149)	0	0	0	0	0	0	0	0	0	0	(34,149)	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):*	(45,490)	0	0	0	0	0	0	0	0	0	0	(45,490)	43
44	**TOTAL Special Cost Centers**	(45,490)	0	0	0	0	0	0	0	0	0	0	(45,490)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(106,441)	(14,200)	0	0	0	0	0	0	0	0	0	(120,641)	45

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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
Danny Frances	33.33					
Jay Frances	33.33					
Kimberly Smith	33.33					

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	Management Fees	$ 360,000	Legacy Health Services	100.00%	$	$ (360,000)	1
2	V	17	Salaries		Legacy Health Services		197,580	197,580	2
3	V	22	Taxes & Insurance		Legacy Health Services		91,720	91,720	3
4	V	21	Telephone		Legacy Health Services		17,500	17,500	4
5	V	21	Travel		Legacy Health Services		30,000	30,000	5
6	V	21	Office Supplies		Legacy Health Services		9,000	9,000	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 360,000			$ 345,800	$ * (14,200)	14

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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
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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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Planters Bank		X	Mortgage Payable	$28,926.82	11/1/08	$ 2,187,000	$ 3,982,258	11/1/28	5.0500	$ 207,814	1
2	Loan from Previous Owners		X	Mortgage Payable	$7,407.84	11/1/08	667,250	309,599	11/1/18	6.0000	20,809	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$36,334.66		$ 2,854,250	$ 4,291,857			$ 228,623	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,127)	10
11	Interest Income	X									(8,711)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,838)	14
15	TOTALS (line 9+line14)						$ 2,854,250	$ 4,291,857			$ 215,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** 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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	81,818	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.)	$	83,460	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,642	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	83,460	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.	$	85,102	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	79,543	8
2010	82,470	9
2011	81,619	10
2012	81,818	11
2013	83,460	12

2014 Accrual = 2013 Real Estate Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor Health Care COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0050161

CONTACT PERSON REGARDING THIS REPORT Rhonda Houchens

TELEPHONE (270) 726-4033 FAX #: (270) 726-8069

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-12-23-251-007	Long Term Care Property	$ 986.64	$ 986.64
2.	10-12-23-251-008	Long Term Care Property	$ 80,319.06	$ 80,319.06
3.	10-12-23-254-001	Long Term Care Property	$ 524.10	$ 524.10
4.	10-12-23-254-002	Long Term Care Property	$ 524.10	$ 524.10
5.	10-12-23-256-003	Long Term Care Property	$ 125.30	$ 125.30
6.	10-12-23-276-005	Long Term Care Property	$ 236.10	$ 236.10
7.	10-12-23-279-005	Long Term Care Property	$ 744.56	$ 744.56
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,459.86	$ 83,459.86

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,539 B. General Construction Type: Exterior Brick Frame _____ 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).

None

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: r4

(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	Facility		2008	$ 211,500	1
2					2
3	TOTALS			$ 211,500	3

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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	230		2008	1964	$ 3,788,500	$	39	$ 97,141	$ 97,141	$ 599,036	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	248,035		20	12,265	12,265	73,588	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

*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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			194,303			(194,303)		69
70	TOTAL (lines 4 thru 69)		$ 4,036,535	$ 194,303		$ 109,406	$ (84,897)	$ 672,624	70

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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		$ 4,036,535	$ 194,303		$ 109,406	$ (84,897)	$ 672,624	1
2	Roof Project-Wing 4	2010	57,268		20	2,863	2,863	14,317	2
3	Sprinkler	2010	4,790		20	240	240	1,198	3
4	2 Water Heaters	2010	2,683		20	134	134	671	4
5	Holland Const/Aci Arch	2010	4,937		20	632	632	3,161	5
6	New Doors	2010	20,473		20	1,024	1,024	5,119	6
7	New Doors	2011	7,360		20	736	736	2,944	7
8	Hvac Repairs	2011	4,414		20	441	441	1,765	8
9	Front Entrance-Demolition, Millwork, Walls, Ceilings, Flooring	2011	34,675		20	1,734	1,734	6,935	9
10	New Roof	2011	5,899		20	590	590	2,360	10
11	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	1,276	11
12	Roof Repair	2011	3,100		20	155	155	620	12
13	Soffit & Fascia	2012	13,148		20	657	657	1,972	13
14	Two Bryant rooftop A/C's	2012	10,525		20	526	526	1,579	14
15	Sewer Line Replacement	2012	15,160		20	758	758	2,274	15
16	Kitchen Tile	2012	3,765		20	188	188	565	16
17	Soffit & Fascia	2012	4,183		20	209	209	627	17
18	Installation of 6" Seamless Guttering	2013	12,782		20	639	639	1,278	18
19	Installation of Walk in Cooler	2013	8,460		20	423	423	846	19
20	Installation of Walk In Freezer	2013	9,130		20	457	457	914	20
21	Roof Replacement	2013	141,706		20	7,085	7,085	14,170	21
22	2 Carrier Ductless Heat Pumps	2013	6,975		20	349	349	698	22
23	Concrete Resurfacing	2013	5,590		20	280	280	560	23
24	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	936	24
25	Dmt Gas Generator #54	2013	6,000		20	300	300	600	25
26	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	4,162	26
27	Rooftop AC Unit	2014	5,355		10	318	318	318	27
28	Rebate on Installation of High Effeciency Lighting	2014	(18,266)		20	(913)	(913)	(913)	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,464,004	$ 194,303		$ 132,099	$ (62,205)	$ 743,576	34

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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	$ 778,257	$	$ 77,826	$ 77,826	10	$ 476,035	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 778,257	$	$ 77,826	$ 77,826		$ 476,035	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 5,453,761	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 194,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 209,925	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,622	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,219,611	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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 3,357 Description: See Attached Schedule
(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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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 Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/14 Ending: 12/31/2014

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	39-03	hrs	$		$ 199,242	$		$ 199,242	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			49,578			49,578	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			200,542	418		200,960	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				71,622		71,622	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					49,961	2,357		52,318	13
14	TOTAL			$		$ 499,323	$ 74,397		$ 573,720	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.

Facility Name & ID Number Friendship Manor Health Care **#** 0050161 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 **(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	$ 71,021	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,357,970		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,500		6
7	Other Prepaid Expenses	6,822		7
8	Accounts Receivable (owners or related parties)	326,375		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,796,688	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	212,336		13
14	Buildings, at Historical Cost	4,388,880		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	821,418		16
17	Accumulated Depreciation (book methods)	(1,677,641)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	323,137		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,068,130	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,864,818	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 302,856	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	135,938		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,460		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	137,958		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 660,212	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,291,856		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)**	$ 4,291,856	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,952,068	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 912,750	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,864,818	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 962,276	1
2	Restatements (describe):		2
3	**Prior Year Contribution/Draws**	(171,392)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 790,884	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,975	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	61,891	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)**	$ 121,866	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)**	$ 912,750	24 *

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

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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	$ 5,038,711	1
2	Discounts and Allowances for all Levels	(725,227)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,313,484	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,479,502	6
7	Oxygen	8,028	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,487,530	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	2,026	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,368	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	65,335	19
20	Radiology and X-Ray	5,194	20
21	Other Medical Services	34,556	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 184,479	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,838	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,838	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending Income	1,026	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,026	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,999,357	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,243,464	31
32	Health Care	2,012,316	32
33	General Administration	1,181,736	33
	B. Capital Expense		
34	Ownership	548,318	34
	C. Ancillary Expense		
35	Special Cost Centers	622,070	35
36	Provider Participation Fee	331,478	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,939,382	40
41	**Income before Income Taxes (line 30 minus line 40)****	59,975	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 59,975	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,943,144	44
45	Private Pay - Net Inpatient Revenue	2,124,231	45
46	Medicare - Net Inpatient Revenue	42,622	46
47	Other-(specify) Pvt Insurance	102,901	47
48	Other-(specify) Hospice	100,585	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,313,483	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Incomplete 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.**

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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	1,852	2,080	$ 70,272	$ 33.78	1
2	Assistant Director of Nursing	1,912	2,080	50,987	24.51	2
3	Registered Nurses	7,266	8,336	196,305	23.55	3
4	Licensed Practical Nurses	31,806	34,364	607,681	17.68	4
5	CNAs & Orderlies	72,268	75,560	823,301	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,468	6,842	69,690	10.19	10
11	Social Service Workers	3,020	3,358	48,580	14.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,160	25,324	278,145	10.98	15
16	Dishwashers					16
17	Maintenance Workers	3,880	4,247	79,264	18.66	17
18	Housekeepers	18,431	20,147	226,889	11.26	18
19	Laundry	6,990	7,586	79,658	10.50	19
20	Administrator	1,856	2,080	90,759	43.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,814	4,256	89,921	21.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,924	2,096	28,296	13.50	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,870	2,080	45,490	21.87	33
34	TOTAL (lines 1 - 33)	186,517	200,436	$ 2,785,238 *	$ 13.90	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	191	$ 9,050	01-03	35
36	Medical Director	96	9,475	09-03	36
37	Medical Records Consultant	18	920	10-03	37
38	Nurse Consultant	40	4,500	10-03	38
39	Pharmacist Consultant	36	3,415	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	75	4,492	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	456	$ 31,852		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Lietz	Administrator	0	$ 90,759
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,759

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
McMahon Berger PC	Legal Fees	$ 2,759
Frost, Ruttenberg & Rothblatt	Accounting	8,000
Calhoun & Co, CPS	Accounting	985
Point Click Care	Computer Services	17,866
McKesson Medical	Computer Services	3,660
Asher Business System	Computer Services	1,392
CIT	Computer Services	6,531
Casamba, Inc	Computer Services	2,750
UST	Computer Services	(425)
Safe Mode	Computer Services	6,005
ALCO	Computer Services	20
See Supplemental Schedule		16,588
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 66,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,849
Unemployment Compensation Insurance	
FICA Taxes	290,866
Employee Health Insurance	133,148
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation Expense	10,854
TOTAL (agree to Schedule V, line 22, col.8)	$ 500,717

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	4,076
Health Care Worker Background Check	1,300
(Indicate # of checks performed 62)	
Patient Background Checks 20	710
Dues & Subscriptions	1,201
Licenses & Fees	6,950
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,217

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	612
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 612

* Attach copy of IMRF notifications

**See instructions.

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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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(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? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,444** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **331,478**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,026**

(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? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

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XIX:Support Schedules

C. Professional Services

Vendor/Payee	Type	Amount
GHA Technologies	Computer Services	$ 621
Pitney Bowes	Computer Services	448
Accelerated Medical Billing	Consulting Fees	105
Abacus Paysystems	Payroll Processing	14,940
B.O.M, Care Plans	Computer Services	474
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 16,588