

Facility Name & ID Number Friendship Vlg Schaumburg

0023218 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	250	Skilled (SNF)	250	91,250	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	250	TOTALS	250	91,250	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,800	45,571	13,589	76,960	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,800	45,571	13,589	76,960	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.34%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Home Health, Clinic, Adult Day Care

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

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

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1977

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 250 and days of care provided 13,589

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 03/31/2014 Fiscal Year: 03/31/2014

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

Facility Name & ID Number

Friendship Vlg Schaumburg

0023218

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	1,918,117	212,518	1,091,351	3,221,986		3,221,986	(1,420,187)	1,801,799		1
2	Food Purchase		1,605,417		1,605,417		1,605,417	(729,416)	876,001		2
3	Housekeeping	1,041,285	149,069	25,752	1,216,106		1,216,106	(1,122,716)	93,390		3
4	Laundry	250,183	59,655	9,970	319,808		319,808	(26,683)	293,125		4
5	Heat and Other Utilities			1,739,492	1,739,492		1,739,492	(1,605,909)	133,583		5
6	Maintenance	1,567,179	275,450	1,174,929	3,017,558		3,017,558	(2,785,827)	231,731		6
7	Other (specify):*										7
8	TOTAL General Services	4,776,764	2,302,109	4,041,494	11,120,367		11,120,367	(7,690,738)	3,429,629		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	7,261,318	603,402	311,209	8,175,929		8,175,929		8,175,929		10
10a	Therapy	80,758		1,639,972	1,720,730		1,720,730		1,720,730		10a
11	Activities	43,818	3,657	2,034	49,509		49,509		49,509		11
12	Social Services	392,662			392,662		392,662		392,662		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,778,556	607,059	1,989,215	10,374,830		10,374,830		10,374,830		16
	C. General Administration										
17	Administrative			3,891,924	3,891,924	1,194,221	5,086,145	(2,933,111)	2,153,034		17
18	Directors Fees										18
19	Professional Services			1,019	1,019		1,019	(941)	78		19
20	Dues, Fees, Subscriptions & Promotions			48,372	48,372		48,372		48,372		20
21	Clerical & General Office Expenses	119,273	40,712	669,732	829,717	(1,194,221)	(364,504)	(1,174,758)	(1,539,262)		21
22	Employee Benefits & Payroll Taxes			4,056,709	4,056,709		4,056,709	(2,398,008)	1,658,701		22
23	Inservice Training & Education										23
24	Travel and Seminar			49,074	49,074		49,074		49,074		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			588,900	588,900		588,900	(543,676)	45,224		26
27	Other (specify):*										27
28	TOTAL General Administration	119,273	40,712	9,305,730	9,465,715		9,465,715	(7,050,494)	2,415,221		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,674,593	2,949,880	15,336,439	30,960,912		30,960,912	(14,741,232)	16,219,680		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.

STATE OF ILLINOIS

Part V Supplement

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning 04/01/2013 Ending: 03/31/2014

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

		To Line	From Line
Reclassify administrative wages	\$ 1,194,221	17	21

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,140,806	7,140,806		7,140,806	(6,821,221)	319,585			30
31	Amortization of Pre-Op. & Org.			154,203	154,203		154,203	(136,426)	17,777			31
32	Interest			6,561,347	6,561,347		6,561,347	(6,193,459)	367,888			32
33	Real Estate Taxes			470,476	470,476		470,476	(434,346)	36,130			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,326	14,326		14,326		14,326			35
36	Other (specify):*											36
37	TOTAL Ownership			14,341,158	14,341,158		14,341,158	(13,585,452)	755,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	72,184	743,889	185,498	1,001,571		1,001,571		1,001,571			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	55,403	14,202		69,605		69,605	(111,736)	(42,131)			41
42	Provider Participation Fee			516,850	516,850		516,850		516,850			42
43	Other (specify):* Marketing/HH/Me	3,209,006	594,370	2,194,126	5,997,502		5,997,502	(5,997,502)				43
44	TOTAL Special Cost Centers	3,336,593	1,352,461	2,896,474	7,585,528		7,585,528	(6,109,238)	1,476,290			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	16,011,186	4,302,341	32,574,071	52,887,598		52,887,598	(34,435,922)	18,451,676			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 Vlg Schaumburg

0023218

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,697)	02		4
5	Telephone, TV & Radio in Resident Rooms	(197,568)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(415,583)	21		24
25	Fund Raising, Advertising and Promotional				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 Non-Allowable Expenses	(33,171,563)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,803,411)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(632,511)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (632,511)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (34,435,922)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY						
48		49		50		51
						52

Friendship Vlg Schaumburg

ID# 0023218

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Machine Revenue	\$ (3,083)	02	1
2	Investment Income	(1,770,769)	32	2
3	Gift and Coffee Shop Income	(111,736)	41	3
4	Assisted Living/Independent Living	(2,546,704)	43	4
5	Marketing Wages	(878,608)	43	5
6	Marketing Expenses	(1,785,321)	43	6
7				7
8	Bridgewater Place Depreciation	(2,979,228)	30	8
9	Amortization of Bond Costs	(136,426)	31	9
10	Rental of Facility Space	(37,245)	21	10
11	Home Health Wages	(780,742)	43	11
12	Home Health Expenses	(6,127)	43	12
13	Misc. Income	(33,898)	21	13
14	Special Meal Charge	(5,130)	4	14
15				15
16	Non-I-ICC Adjustment:			16
17	Dietary	(1,420,187)	1	17
18	Food Purchase	(707,636)	2	18
19	Housekeeping	(1,122,716)	3	19
20	Laundry	(21,553)	4	20
21	Heat & Utilities	(1,605,909)	5	21
22	Maintenance	(2,785,827)	6	22
23	Administrative	(2,300,600)	17	23
24	Professional Services	(941)	19	24
25	Clerical & General	(490,464)	21	25
26	Employee Benefits	(2,398,008)	22	26
27	Insurance	(543,676)	26	27
28	Depreciation	(3,841,993)	30	28
29	Interest	(4,422,690)	32	29
30	Real Estate Taxes	(434,346)	33	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	(33,171,563)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Vlg Schaumburg# 0023218

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,420,187)	0	0	0	0	0	0	0	0	0	0	(1,420,187)	1
2	Food Purchase	(729,416)	0	0	0	0	0	0	0	0	0	0	(729,416)	2
3	Housekeeping	(1,122,716)	0	0	0	0	0	0	0	0	0	0	(1,122,716)	3
4	Laundry	(26,683)	0	0	0	0	0	0	0	0	0	0	(26,683)	4
5	Heat and Other Utilities	(1,605,909)	0	0	0	0	0	0	0	0	0	0	(1,605,909)	5
6	Maintenance	(2,785,827)	0	0	0	0	0	0	0	0	0	0	(2,785,827)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,690,738)	0	0	0	0	0	0	0	0	0	0	(7,690,738)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(2,300,600)	(632,511)	0	0	0	0	0	0	0	0	0	(2,933,111)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(941)	0	0	0	0	0	0	0	0	0	0	(941)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,174,758)	0	0	0	0	0	0	0	0	0	0	(1,174,758)	21
22	Employee Benefits & Payroll Taxes	(2,398,008)	0	0	0	0	0	0	0	0	0	0	(2,398,008)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(543,676)	0	0	0	0	0	0	0	0	0	0	(543,676)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(6,417,983)	(632,511)	0	0	0	0	0	0	0	0	0	(7,050,494)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,108,721)	(632,511)	0	0	0	0	0	0	0	0	0	(14,741,232)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Vlg Schaumburg# 0023218

Report Period Beginning:

04/01/2013 Ending:

03/31/2014

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,821,221)	0	0	0	0	0	0	0	0	0	0	(6,821,221)	30
31	Amortization of Pre-Op. & Org.	(136,426)	0	0	0	0	0	0	0	0	0	0	(136,426)	31
32	Interest	(6,193,459)	0	0	0	0	0	0	0	0	0	0	(6,193,459)	32
33	Real Estate Taxes	(434,346)	0	0	0	0	0	0	0	0	0	0	(434,346)	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	(13,585,452)	0	0	0	0	0	0	0	0	0	0	(13,585,452)	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	(111,736)	0	0	0	0	0	0	0	0	0	0	(111,736)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,997,502)	0	0	0	0	0	0	0	0	0	0	(5,997,502)	43
44	TOTAL Special Cost Centers	(6,109,238)	0	0	0	0	0	0	0	0	0	0	(6,109,238)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(33,803,411)	(632,511)	0	0	0	0	0	0	0	0	0	(34,435,922)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 3,891,924	Friendship Village Executive/Corporate Allocation		\$ 3,259,413	\$ (632,511)	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,891,924			\$ 3,259,413	\$ * (632,511)	14

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

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	See attached board of directors listing.							2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	See Attached Board of Directors listing.								\$	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 Vlg Schaumburg

0023218 Report Period Beginning: 04/01/2013

Ending: 3/31/2014

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

Name of Related Organization Friendship Senior Options
 Street Address 350 W. Schaumburg Road
 City / State / Zip Code Schaumburg, IL 60194
 Phone Number (847) 490-6271
 Fax Number ()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Meals Ratio	408,748	2	\$ 3,221,986	\$ 2,488,249	228,580	\$ 1,801,799	1
2	2	Food Purchase	Meals Ratio	408,748	2	1,605,417	0	228,580	897,781	2
3	3	Housekeeping	Square Feet	737,530	2	1,216,106	1,041,285	56,638	93,390	3
4	4	Laundry	Pounds	1,011,272	2	319,808	250,183	943,119	298,255	4
5	5	Heat & Utilities	Square Feet	737,530	2	1,739,492	0	56,638	133,583	5
6	6	Maintenance	Square Feet	737,530	2	3,017,558	1,567,179	56,638	231,731	6
7	7	Other (disposal, waste)	Square Feet	737,530	2	0	0	56,638	0	7
8	17	Administrative	Employee Ratio	428	2	3,891,924	0	175	1,591,324	8
9	19	Professional Services	Square Feet	737,530	2	1,019	0	56,638	78	9
10	21	Clerical & General	Employee Ratio	428	2	829,717	119,273	175	339,253	10
11	22	Employee Benefits	Employee Ratio	428	2	4,056,709	0	175	1,658,701	11
12	26	Insurance	Square Feet	737,530	2	588,900	0	56,638	45,224	12
13	30	Depreciation	Actual	737,530	2	4,161,578	0	56,638	319,585	13
14	32	Interest	Square Feet	737,530	2	4,790,578	0	56,638	367,888	14
15	33	Real Estate Taxes	Square Feet	737,530	2	470,476	0	56,638	36,130	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 29,911,268	\$ 5,466,169		\$ 7,814,722	25

Facility Name & ID Number

Friendship Vlg Schaumburg

0023218

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Revenue Bond Series 2005		X	Bond Issuance			\$ 80,500,000	\$ 73,239,207		Variable	\$ 4,141,080	1				
2	Revenue Bond Series 2010		X	Bond Issuance			33,610,000	33,054,996		Variable	2,413,167	2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 114,110,000	\$ 106,294,203			\$ 6,554,247	9				
B. Non-Facility Related*																
10	Investment Income										(1,770,769)	10				
11												11				
12												12				
13	See Supplemental Schedule										(4,422,690)	13				
14	TOTAL Non-Facility Related						\$	\$			\$ (6,193,459)	14				
15	TOTALS (line 9+line14)						\$ 114,110,000	\$ 106,294,203			\$ 360,788	15				

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	337,701		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.)		\$	288,493		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(49,208)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	519,869		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.)		\$	(185)		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.		\$	470,476		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>521,222</u>	8		
	2010	<u>593,438</u>	9		
	2011	<u>507,365</u>	10		
	2012	<u>472,710</u>	11		
	2013	<u>288,493</u>	12		
				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.

Friendship Vlg Schaumburg
03/31/2014
RE Tax Reconciliation

	<u>BEGINNING BALANCE</u>	<u>ACCRUAL</u>	<u>ADJUSTMENT/ REFUND</u>	<u>PAYMENT</u>	<u>DESCRIPTION</u>	<u>ENDING BALANCE</u>
4/30/2013	(337,701.08)	(45,833.00)				(383,534.08)
5/31/2013	(383,534.08)	(45,833.00)		1,405.28	Kane County 2012 1st Inst	(427,961.80)
6/30/2013	(427,961.80)	(45,833.00)				(473,794.80)
7/31/2013	(473,794.80)	(28,833.00)		92,056.53	2012 Cook 2nd installment	(410,571.27)
8/31/2013	(410,571.27)	(28,833.00)		1,405.28	Kane County 2012 2nd Inst	(437,998.99)
9/30/2013	(437,998.99)	(28,833.00)				(466,831.99)
10/31/2013	(466,831.99)	(28,833.00)				(495,664.99)
11/30/2013	(495,664.99)	(28,833.00)	(184.97)		Cook County Tax REF	(524,682.96)
12/31/2013	(524,682.96)	(28,833.00)				(553,515.96)
1/31/2014	(553,515.96)	(28,833.00)				(582,348.96)
2/28/2014	(582,348.96)	68,244.45		193,625.84	2013 Cook 1st installment	(320,478.67)
3/31/2014	(320,478.67)	(199,390.72)				(519,869.39)
		<u>(470,476)</u>	<u>(184.97)</u>	<u>288,492.93</u>		
		TB 10-01-98-9600-00				TB 10-00-00-2230-00

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Vlg Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023218

CONTACT PERSON REGARDING THIS REPORT Jeff Nyberg

TELEPHONE 847-843-4259 FAX #: 847-884-5718

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-22-100-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>278,571.70</u>	\$ <u>21,392.68</u>
2. <u>07-22-101-042-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,110.67</u>	\$ <u>546.06</u>
3. <u>02-08-401-018</u>	<u>Long Term Care Property</u>	\$ <u>2,810.56</u>	\$ <u>215.83</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>288,492.93</u></u>	\$ <u><u>22,154.57</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES 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.**

Friendship Vlg Schaumburg
 03/31/2014
 RE Tax Allocation

<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
07-22-100-026-0000	Long Term Care Property	\$ 278,572	21,393
07-22-101-042-0000	Long Term Care Property	\$ 7,111	546
02-08-401-018	Long Term Care Property	\$ 2,811	216

<u>Allocation Calculation</u>			
	<u>Facility Units</u>	<u>Total Units</u>	<u>% Applicable to Nursing Home</u>
Page 8 Housekeeping	56,638	737,530	8%

<u>Tax ID</u>	<u>Total Tax</u>	<u>Allocation %</u>	<u>Tax Applicable to Nursing Home</u> <u>(Total Tax * Allocation %)</u>
07-22-100-026-0000	278,572	8%	21,393
07-22-101-042-0000	7,111	8%	546
02-08-401-018	2,811	8%	216

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 737,530 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Bridgeway Apartments - Independent Living Apartments - Buildings Separate From SNI

Bridgewater Place Apartment Homes - Independent Living Apartment Home - Buildings Separate From SNI

Crosswell Terrace Garden Homes - Independent Living Homes - Buildings Separate From SNI

The Willows Assisted Living - Buildings Separate From SNF

Reflections - Memory Support - Buildings SeperateFrom SNF

Clinic - 364,499 Square Feet of Space in Building Where SNF is Located

Home Care - 1,888 Square Feet in Building Where SNF is Located.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>SNF</u>	<u>Approx. 50</u>	<u>1977</u>	<u>\$ 132,065</u>	1
2	<u>Non-Allowable</u>			<u>4,392,192</u>	2
3	TOTALS	#VALUE!		\$ 4,524,257	3

Facility Name & ID Number Friendship Vlg Schaumburg

0023218

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	180		1977	1977	\$ 1,760,825	\$ 44,021	40	\$ 44,021	\$	\$
5	10		1993	1993	1,102,771	27,569	40	27,569		
6	60		1998	1998	2,934,069	73,352	40	73,352		
7										
8										
	Improvement Type**									
9		1994 Fixed Assets	1994		192,354		Various			
10		1995 Fixed Assets	1995		148,003		Various			
11		1997 Fixed Assets	1997		470,386		Various			
12		1998 Fixed Assets	1998		135,637		Various			
13		1999 Fixed Assets	1999		134,210		Various			
14		2000 Fixed Assets	2000		33,116		Various			
15		2001 Fixed Assets	2001				Various			
16		2002 Fixed Assets	2002		27,260		Various			
17		2003 Fixed Assets	2003		37,618		Various			
18		2005 Fixed Assets	2005		131,485		Various			
19		2006 Fixed Assets	2006		620,324		Various			
20		Gazebo Landscaping	2008		3,348		20			
21		HCC Gazebo Replacement	2008		26,460		10			
22		HCC Special Care Phase II Design Cost Only	2008		74,919		10			
23		HCC Special Care Phase II Renovation	2008		174,683		10			
24		Parking Garage	2010		21,766		10			
25		Briarwood Anti-Elopement Door	2010		130,985		15			
26		Associate Store Renovation	2010		4,499		15			
27		Contrete work in Gazebo courtyard	2011		4,070		15			
28		Special Care Awning	2011		4,850		5			
29		"E" Supply Room	2011		3,362		15			
30		"F" Supply Room	2011		3,589		15			
31		Bridgegate Garage Door Replacements	2012		4,650		15			
32		Replace 4 External Doors in Health Center	2012		5,060		10			
33		Renovations of Pavilion E & F	2013		2,004,128		20			
34										
35		Financial Statement Depreciation				174,643		174,643		
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

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	\$ 1,890,951	\$	\$	\$		\$	71
72	Current Year Purchases	1,468,427						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,359,378	\$	\$	\$		\$	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		Van	2005	\$ 20,852	\$	\$	\$	5	\$	76
77		Pick-up Truck	2005	18,259				5		77
78										78
79										79
80	TOTALS			\$ 39,111	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 18,117,173 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 319,585 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 319,585 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 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	Marketing/HR/Admin/Foundation Off	\$ 2,618,568	\$	\$	86
87	AL/IL/HH	66,167,709			87
88	Bridgewater	84,177,047			88
89	Friendship Center/MillCreek	5,845,166			89
90	Beauty Shop/Clinic/Commons/Dining/Lau	5,867,692			90
91	TOTALS	\$ 164,676,182	\$	\$	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 Vlg Schaumburg

0023218

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

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

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 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,326 Description: Various medical equipment items.

(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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10a-3	hrs	\$	6,142	\$	425,008	\$	6,142	\$	425,008	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,530		181,653		2,530		181,653	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10a-3	hrs		10,666		765,596		10,666		765,596	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39-2	# of prescripts					743,889			743,889	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			\$	19,338	\$	1,372,257	\$	743,889	19,338	\$	2,116,146	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 Vlg Schaumburg# 0023218Report Period Beginning: 04/01/2013Ending: 03/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2014

(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	\$ 3,157,730	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>475,363</u>)	6,544,653		3
4	Supply Inventory (priced at <u>cost</u>)	106,623		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,308		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	9,249,661		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,078,975	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	22,111,759		12
13	Land	4,524,257		13
14	Buildings, at Historical Cost	119,358,863		14
15	Leasehold Improvements, at Historical Cost	44,902,188		15
16	Equipment, at Historical Cost	14,008,047		16
17	Accumulated Depreciation (book methods)	(74,642,938)		17
18	Deferred Charges	1,226,324		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): <u>See Attached Schedule</u>	4,941,917		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 136,430,417	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 155,509,392	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 8,911,877	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,327,887		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,852		31
32	Accrued Real Estate Taxes(Sch.IX-B)	519,869		32
33	Accrued Interest Payable	781,293		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	286,724		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,829,502	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	106,366,050		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	94,087,327		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 200,453,377	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 212,282,879	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (56,773,487)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 155,509,392	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (52,216,804)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (52,216,804)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,556,680)	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) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,556,683)	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)	\$ (56,773,487)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,285,099	1
2	Discounts and Allowances for all Levels	(2,200,880)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,084,219	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	429,983	6
7	Oxygen	73,106	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 503,089	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	114,819	12
13	Barber and Beauty Care	9,689	13
14	Non-Patient Meals	49,499	14
15	Telephone, Television and Radio	197,568	15
16	Rental of Facility Space	37,245	16
17	Sale of Drugs	98,836	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,709	19
20	Radiology and X-Ray		20
21	Other Medical Services	479,722	21
22	Laundry	44,653	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,076,740	23
D. Non-Operating Revenue			
24	Contributions	185,023	24
25	Interest and Other Investment Income***	2,164,737	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,349,760	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>IL/AL/HH Revenue</u>	25,286,497	28
28a	<u>Other Revenue</u>	30,613	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,317,110	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 48,330,918	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	11,120,367	31
32	Health Care	10,374,830	32
33	General Administration	9,465,715	33
B. Capital Expense			
34	Ownership	14,341,158	34
C. Ancillary Expense			
35	Special Cost Centers	7,068,678	35
36	Provider Participation Fee	516,850	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 52,887,598	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,556,680)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,556,680)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,401,748	44
45	Private Pay - Net Inpatient Revenue	2,906,419	45
46	Medicare - Net Inpatient Revenue	7,409,630	46
47	Other-(specify) <u>Hospice/Life Care</u>	6,366,422	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,084,219	49

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

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

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

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

Facility Name & ID Number Friendship Vlg Schaumburg

0023218

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,904	2,080	\$ 102,232	\$ 49.15	1
2	Assistant Director of Nursing	5,979	7,024	277,968	39.57	2
3	Registered Nurses	67,680	81,307	2,612,755	32.13	3
4	Licensed Practical Nurses	19,151	22,534	613,245	27.21	4
5	CNAs & Orderlies	165,768	191,049	2,626,116	13.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,240	8,215	220,772	26.87	8
9	Activity Director					9
10	Activity Assistants	33,109	36,492	483,759	13.26	10
11	Social Service Workers	12,359	13,551	304,340	22.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	130,957	144,890	1,638,782	11.31	15
16	Dishwashers	25,602	27,769	282,119	10.16	16
17	Maintenance Workers	28,032	33,939	660,814	19.47	17
18	Housekeepers	84,724	95,606	1,094,888	11.45	18
19	Laundry	19,370	21,619	250,267	11.58	19
20	Administrator	1,816	2,080	134,804	64.81	20
21	Assistant Administrator	1,792	2,080	65,982	31.72	21
22	Other Administrative	28,124	31,802	993,435	31.24	22
23	Office Manager					23
24	Clerical	55,562	61,986	917,232	14.80	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	14,731	16,929	233,646	13.80	31
32	Other Health C: <u>AL/IL/HH</u>	90,843	101,411	1,744,522	17.20	32
33	Other(specify) <u>Mrktg/Store</u>	22,295	24,639	753,508	30.58	33
34	TOTAL (lines 1 - 33)	817,038	927,002	\$ 16,011,186 *	\$ 17.27	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 36,000	9-3	36
37	Medical Records Consultant	Monthly 1,576	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 15,294	10-3	39
40	Physical Therapy Consultant	10,666	765,596 10a-3	40
41	Occupational Therapy Consultant	6,142	425,008 10a-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	2,530	181,653 10a-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Dietary Outside Labor	Monthly 341,731	1-03	47
48	MDS Coordinator	190	17,980 10-03	48
49	TOTAL (lines 35 - 48)	19,528	\$ 1,784,838	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	168	3,825	52
53	TOTAL (lines 50 - 52)	168	\$ 3,825	53

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Friendship Vlg Schaumburg

0023218

Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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. LSN \$ 31,603, CARF \$5,356
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Year
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 95,451 Line 10-2
- (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. \$ 516,850
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? Yes (see page 8) 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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 89,582
- (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? None
- 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? Yes
Firm Name: CliftonLarsonAllen LLP
- (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.