		FOR BHF USE				

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0050161

Facility Name: Friendship Manor Health Ctr

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: 11/1/08

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] 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 01/01/2015 to 12/31/2015 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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 9/4/2015

	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	230	Skilled (SNF)	150	74,430	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	150	74,430	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,513	15,390	4,098	36,001	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,513	15,390	4,098	36,001	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.37%

D. How many bed-hold days during this year were paid by the Department?
3 (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 150 and days of care provided 2,912

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Friendship Manor Health Ctr #0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			193,325	193,325		193,325	18,613	211,938			30
31	Amortization of Pre-Op. & Org.			36,933	36,933		36,933	(36,933)				31
32	Interest			217,090	217,090		217,090	(9,895)	207,195			32
33	Real Estate Taxes			79,879	79,879		79,879		79,879			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,541	3,541		3,541		3,541			35
36	Other (specify):*											36
37	TOTAL Ownership			530,768	530,768		530,768	(28,215)	502,553			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,079	2,079		2,079		2,079			38
39	Ancillary Service Centers		85,588	434,904	520,492		520,492		520,492			39
40	Barber and Beauty Shops		110		110		110		110			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			312,488	312,488		312,488		312,488			42
43	Other (specify):* Marketing Salary					44,372	44,372	(44,372)				43
44	TOTAL Special Cost Centers		85,698	749,471	835,169	44,372	879,541	(44,372)	835,169			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,808,560	448,443	2,705,275	5,962,278		5,962,278	(138,724)	5,823,554			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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	274,866	16,322	9,001	300,189		300,189		300,189			1
2	Food Purchase		218,580		218,580		218,580	(858)	217,722			2
3	Housekeeping	222,914	21,955		244,869		244,869		244,869			3
4	Laundry	77,321	16,737		94,058		94,058		94,058			4
5	Heat and Other Utilities			190,664	190,664		190,664	(11,279)	179,385			5
6	Maintenance	83,135	1,177	62,104	146,416		146,416		146,416			6
7	Other (specify):*			7,600	7,600		7,600		7,600			7
8	**TOTAL General Services**	658,236	274,771	269,369	1,202,376		1,202,376	(12,137)	1,190,239			8
	B. Health Care and Programs											
9	Medical Director			11,100	11,100		11,100		11,100			9
10	Nursing and Medical Records	1,791,437	72,338	117,388	1,981,163	13,990	1,995,153		1,995,153			10
10a	Therapy											10a
11	Activities	68,574	4,202	10,875	83,651		83,651	(2,215)	81,436			11
12	Social Services	104,165	169		104,334	(44,372)	59,962		59,962			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,964,176	76,709	139,363	2,180,248	(30,382)	2,149,866	(2,215)	2,147,651			16
	C. General Administration											
17	Administrative	93,604		360,000	453,604		453,604	(149,000)	304,604			17
18	Directors Fees											18
19	Professional Services			79,544	79,544	(14,418)	65,126	(17,140)	47,986			19
20	Dues, Fees, Subscriptions & Promotions			24,015	24,015		24,015	(6,208)	17,807			20
21	Clerical & General Office Expenses	92,544	11,265	45,261	149,070	428	149,498	41,363	190,861			21
22	Employee Benefits & Payroll Taxes			410,098	410,098		410,098	79,200	489,298			22
23	Inservice Training & Education			2,674	2,674		2,674		2,674			23
24	Travel and Seminar			165	165		165		165			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,547	94,547		94,547		94,547			26
27	Other (specify):*											27
28	**TOTAL General Administration**	186,148	11,265	1,016,304	1,213,717	(13,990)	1,199,727	(51,785)	1,147,942			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,808,560	362,745	1,425,036	4,596,341	(44,372)	4,551,969	(66,137)	4,485,832			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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(395)	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	18,613	30		9
10	Interest and Other Investment Income	(9,895)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(463)	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	(101)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,140)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,126)	21		24
25	Fund Raising, Advertising and Promotional	(6,208)	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	(96,809)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,524)		$	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))**	$ (138,724)		37

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

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

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

STATE OF ILLINOIS

Friendship Manor Health Ctr

ID# 0050161

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (2,010)	21	1
2	Flowers	(2,215)	11	2
3	Plant Cable	(11,279)	05	3
4	Amortization	(36,933)	31	4
5	Non-Allowable Seminar			5
6	Marketing Salary	(44,372)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(96,809)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(858)	0	0	0	0	0	0	0	0	0	0	(858)	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	(11,279)	0	0	0	0	0	0	0	0	0	0	(11,279)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,137)	0	0	0	0	0	0	0	0	0	0	(12,137)	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	(2,215)	0	0	0	0	0	0	0	0	0	0	(2,215)	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	(2,215)	0	0	0	0	0	0	0	0	0	0	(2,215)	16
	C. General Administration													
17	Administrative	0	(149,000)	0	0	0	0	0	0	0	0	0	(149,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,140)	0	0	0	0	0	0	0	0	0	0	(17,140)	19
20	Fees, Subscriptions & Promotions	(6,208)	0	0	0	0	0	0	0	0	0	0	(6,208)	20
21	Clerical & General Office Expenses	(14,237)	55,600	0	0	0	0	0	0	0	0	0	41,363	21
22	Employee Benefits & Payroll Taxes	0	79,200	0	0	0	0	0	0	0	0	0	79,200	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	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	(37,585)	(14,200)	0	0	0	0	0	0	0	0	0	(51,785)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,937)	(14,200)	0	0	0	0	0	0	0	0	0	(66,137)	29

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	18,613	0	0	0	0	0	0	0	0	0	0	18,613	30
31	Amortization of Pre-Op. & Org.	(36,933)	0	0	0	0	0	0	0	0	0	0	(36,933)	31
32	Interest	(9,895)	0	0	0	0	0	0	0	0	0	0	(9,895)	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	(28,215)	0	0	0	0	0	0	0	0	0	0	(28,215)	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):*	(44,372)	0	0	0	0	0	0	0	0	0	0	(44,372)	43
44	TOTAL Special Cost Centers	(44,372)	0	0	0	0	0	0	0	0	0	0	(44,372)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(124,524)	(14,200)	0	0	0	0	0	0	0	0	0	(138,724)	45

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Systems	100.00%	$	$ (360,000)	1
2	V	17	Salaries		Legacy Health Systems		211,000	211,000	2
3	V	22	Taxes & Insurance		Legacy Health Systems		79,200	79,200	3
4	V	21	Telephone		Legacy Health Systems		13,100	13,100	4
5	V	21	Travel		Legacy Health Systems		34,000	34,000	5
6	V	21	Office Supplies				8,500	8,500	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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
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18								18
19								19
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25								25
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29								29
30								30

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 3,835,646	11/1/28	5.0500	$ 200,510	1
2	Loan from Previous Owner		X	Mortgage Payable	$7,407.84	11/1/08	667,250	237,284	11/1/18	6.0000	16,579	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	$ 4,072,930			$ 217,089	9
	B. Non-Facility Related*											
10	Interest Income		X								(818)	10
11	Interest Income	X									(9,077)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,895)	14
15	TOTALS (line 9+line14)						$ 2,854,250	$ 4,072,930			$ 207,194	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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2014 report.	$	83,460	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.)	$	83,236	2
3. Under or (over) accrual (line 2 minus line 1).	$	(224)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	83,236	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.	$	83,012	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2010	82,470	8
2011	81,619	9
2012	81,818	10
2013	83,460	11
2014	83,236	12

2015 Accrual=2014 Real Estate Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor Health Ctr 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 2014 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 2014.

	(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	$ 983.94	$ 983.94
2.	10-12-23-251-008	Long Term Care Property	$ 80,103.48	$ 80,103.48
3.	10-12-23-254-001	Long Term Care Property	$ 522.66	$ 522.66
4.	10-12-23-254-002	Long Term Care Property	$ 522.66	$ 522.66
5.	10-12-23-256-003	Long Term Care Property	$ 125.08	$ 125.08
6.	10-12-23-276-005	Long Term Care Property	$ 235.40	$ 235.40
7.	10-12-23-279-005	Long Term Care Property	$ 742.58	$ 742.58
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,235.80	$ 83,235.80

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:
(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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	150		2008	1964	$ 3,788,500	$	39	$ 97,141	$ 97,141	$ 696,177	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	248,035		20	12,265	12,265	85,853	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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Roof Project-Wing 4	2010	57,268		20	2,863	2,863	17,180	38
39	Sprinkler	2010	4,790		20	240	240	1,438	39
40	2 Water Heaters	2010	2,683		20	134	134	805	40
41	Holland Const/Aci Arch	2010	4,937		20	632	632	3,793	41
42	New Doors	2010	20,473		20	1,024	1,024	6,143	42
43	New Doors	2011	7,360		20	736	736	3,680	43
44	Hvac Repairs	2011	4,414		20	441	441	2,206	44
45	Front Entrance Demolition, Millwork, Walls, Ceilings, Flooring	2011	34,675		20	1,734	1,734	8,669	45
46	New Roof	2011	5,899		20	590	590	2,950	46
47	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	1,595	47
48	Roof Repair	2011	3,100		20	155	155	775	48
49	Soffit & Fascia	2012	13,148		20	657	657	2,629	49
50	Two Bryant rooftop A/Cs	2012	10,525		20	526	526	2,105	50
51	Sewer Line Replacement	2012	15,160		20	758	758	3,032	51
52	Kitchen Tile	2012	3,765		20	188	188	753	52
53	Soffit & Fascia	2012	4,183		20	209	209	836	53
54	Installation of 6" Seamless guttering	2013	12,782		20	639	639	1,917	54
55	Installation of Walk in cooler	2013	8,460		20	423	423	1,269	55
56	Installation of Walk in Freezer	2013	9,130		20	457	457	1,371	56
57	Roof Replacement	2013	141,706		20	7,085	7,085	21,255	57
58	2 Carrier Ductless Heat Pumps	2013	6,975		20	349	349	1,047	58
59	Concrete Resurfacing	2013	5,590		20	280	280	840	59
60	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	1,404	60
61	Dmt Gas Generatior #54	2013	6,000		20	300	300	900	61
62	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	6,243	62
63	Rooftop AC Unit	2014	5,355		10	536	536	854	63
64	Rebate on Installation of High Effeciency Lighting	2014	(18,266)		20	(913)	(913)	(1,826)	64
65	High Efficiency Lighting	2015	14,117		20	628	628	628	65
66									66
67									67
68									68
69	Financial Statement Depreciation			192,158			(192,158)		69
70	TOTAL (lines 4 thru 69)		$ 4,478,121	$ 192,158		$ 132,945	$ (59,213)	$ 876,521	70

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 553,861	71
72	Current Year Purchases	7,292	182	182		10	182	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 785,549	$ 182	$ 78,008	$ 77,826		$ 554,043	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	Facility	1998 HC Chevy Express Van	2015	$ 6,564	$ 985	$ 985	$	5	$ 985	76
77										77
78										78
79										79
80	TOTALS			$ 6,564	$ 985	$ 985	$		$ 985	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)	$ 5,481,734	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,325	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,938	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,431,549	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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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 [X] NO
16. Rental Amount for movable equipment: $ 3,541 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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 175,722	$		$ 175,722	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			42,807			42,807	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			163,018	905		163,923	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				74,196		74,196	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					53,357	10,487		63,844	13
14	TOTAL			$		$ 434,904	$ 85,588		$ 520,492	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 Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ 38,770	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,409,948		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,129		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	108,911		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,595,758	$	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	4,421,263		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	835,274		16
17	Accumulated Depreciation (book methods)	(1,871,879)		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):	286,205		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,883,199	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,478,957	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 233,016	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,948		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,103		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	140,845		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 588,912	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,072,930		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)**	$ 4,072,930	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,661,842	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 817,115	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,478,957	$	48

*(See instructions.)

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 912,750	1
2	Restatements (describe):		2
3	**Prior Year Contributions/Draws**	(61,891)	3
4	**Prior Year Adj for Lighting Rebate/Depreciation**	17,354	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 868,213	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(42,489)	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	(8,609)	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)**	$ (51,098)	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)**	$ 817,115	24 *

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 4,879,676	1
2	Discounts and Allowances for all Levels	(461,768)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,417,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,239,402	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,239,402	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	395	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	79,943	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,778	19
20	Radiology and X-Ray	2,584	20
21	Other Medical Services	81,884	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 252,584	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,895	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,895	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,919,789	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,202,376	31
32	Health Care	2,180,248	32
33	General Administration	1,213,717	33
	B. Capital Expense		
34	Ownership	530,768	34
	C. Ancillary Expense		
35	Special Cost Centers	522,681	35
36	Provider Participation Fee	312,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,962,278	40
41	**Income before Income Taxes (line 30 minus line 40)****	(42,489)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (42,489)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,030,039	44
45	Private Pay - Net Inpatient Revenue	2,075,863	45
46	Medicare - Net Inpatient Revenue	119,466	46
47	Other-(specify) **Private Insurance**	45,084	47
48	Other-(specify) **Hospice**	147,456	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,417,908	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.

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,876	2,100	$ 73,090	$ 34.80	1
2	Assistant Director of Nursing	1,964	2,080	52,510	25.25	2
3	Registered Nurses	10,330	11,443	268,288	23.45	3
4	Licensed Practical Nurses	26,904	29,768	559,980	18.81	4
5	CNAs & Orderlies	68,524	71,853	808,307	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,978	6,424	68,574	10.67	10
11	Social Service Workers	3,658	4,082	59,793	14.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,397	24,526	274,866	11.21	15
16	Dishwashers					16
17	Maintenance Workers	3,708	4,060	83,135	20.48	17
18	Housekeepers	17,625	19,005	222,914	11.73	18
19	Laundry	6,282	7,014	77,321	11.02	19
20	Administrator	1,812	2,080	93,604	45.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,662	4,246	92,544	21.80	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	1,898	2,102	29,262	13.92	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,000	2,080	44,372	21.33	33
34	TOTAL (lines 1 - 33)	178,618	192,863	$ 2,808,560 *	$ 14.56	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	178	$ 8,663	01-03	35
36	Medical Director	96	11,100	09-03	36
37	Medical Records Consultant	16	920	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,000	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	77	5,630	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	403	$ 29,313		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	4,706	106,087	10-03	52
53	TOTAL (lines 50 - 52)	4,706	$ 106,087		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Leitz	Administrator	0	$ 93,604
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 93,604

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
Accelerated Medical Billing	Billing Consulting	$ 578
McMahon Berger PC	Legal Fees	1,013
Resolute Law Office	Legal Fees	17,140
Hargis & Associates, LLC	Accounting	4,270
Calhoun & Compnay	Accounting	1,025
Abacus Paysystems	Payroll Processing	16,920
Pitney Bowes	Computer Services	917
Casamba	Computer Services	3,000
Mckesson Medical	Computer Services	3,992
Point ClickCare	Computer Services	19,672
Purchase Power	Computer Services	287
See Supplemental Schedule		10,730
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 79,544

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,405
Unemployment Compensation Insurance	
FICA Taxes	257,727
Employee Health Insurance	112,610
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation Expense	13,556
TOTAL (agree to Schedule V, line 22, col.8)	$ 489,298

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		12,378
Health Care Worker Background Check		1,655
(Indicate # of checks performed	26)	
Patient Background Checks	68	710
Dues & Subscriptions		571
License & Fees		2,443
Professional fees		50
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 17,807

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	165
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 165

**See instructions.

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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		$		$	$	$	$	$	$	$	$	$

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? **Yes** If YES, what is the capacity? **150**

(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. $ **10,529** 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. $ **312,488**
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. $ **N/A** Has any meal income been offset against related costs? ____ Indicate the amount. $ ____

(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 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.