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: 0023218

Facility Name: Friendship Vlg Schaumburg

Address: 350 W Schaumburg Rd (Number) Schaumburg (City) 60194 (Zip Code)

County: Cook

Telephone Number: (847)843-4259 **Fax #** (847)884-5718

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Deb Freeland **Telephone Number:** 317-574-9100
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 04/01/2014 to 03/31/2015 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) Jeff Nyberg
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Deb Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-574-9100 Fax # 317-574-9707

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 Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,372	40,205	14,458	77,035	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,372	40,205	14,458	77,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.42%

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 [X]

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 250 and days of care provided 14,458

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: 3/31/2015 Fiscal Year: 3/31/2015

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

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,985,743	343,677	1,174,766	3,504,186		3,504,186	(1,514,277)	1,989,909			1
2	Food Purchase		2,144,502		2,144,502		2,144,502	(955,617)	1,188,885			2
3	Housekeeping	1,067,443	154,653	29,710	1,251,806		1,251,806	(1,155,675)	96,131			3
4	Laundry	261,269	72,691	16,514	350,474		350,474	(22,439)	328,035			4
5	Heat and Other Utilities			1,824,639	1,824,639		1,824,639	(1,733,481)	91,158			5
6	Maintenance	1,576,109	171,643	1,147,644	2,895,396		2,895,396	(2,673,046)	222,350			6
7	Other (specify):*											7
8	TOTAL General Services	4,890,564	2,887,166	4,193,273	11,971,003		11,971,003	(8,054,535)	3,916,468			8
	B. Health Care and Programs											
9	Medical Director			27,750	27,750		27,750		27,750			9
10	Nursing and Medical Records	7,477,257	701,187	344,858	8,523,302	(136,951)	8,386,351		8,386,351			10
10a	Therapy	80,472		1,645,391	1,725,863		1,725,863		1,725,863			10a
11	Activities	201,490	4,829	5,372	211,691		211,691		211,691			11
12	Social Services	425,027			425,027		425,027		425,027			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,184,246	706,016	2,023,371	10,913,633	(136,951)	10,776,682		10,776,682			16
	C. General Administration											
17	Administrative			3,818,628	3,818,628	136,951	3,955,579	(2,773,639)	1,181,940			17
18	Directors Fees											18
19	Professional Services			19,572	19,572		19,572	(18,069)	1,503			19
20	Dues, Fees, Subscriptions & Promotions			53,635	53,635		53,635		53,635			20
21	Clerical & General Office Expenses		5,361	911,441	916,802		916,802	(871,503)	45,299			21
22	Employee Benefits & Payroll Taxes			4,346,456	4,346,456		4,346,456	(2,596,461)	1,749,995			22
23	Inservice Training & Education											23
24	Travel and Seminar			36,183	36,183		36,183		36,183			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			646,431	646,431		646,431	(596,789)	49,642			26
27	Other (specify):*											27
28	TOTAL General Administration		5,361	9,832,346	9,837,707	136,951	9,974,658	(6,856,461)	3,118,197			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	13,074,810	3,598,543	16,048,990	32,722,343		32,722,343	(14,910,996)	17,811,347			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.

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

		To Line	From Line
Reclassify administrative wages	$ 136,951	17	21

Facility Name & ID Number Friendship Vlg Schaumburg #0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,587,272	7,587,272		7,587,272	(6,825,742)	761,530			30
31	Amortization of Pre-Op. & Org.			151,972	151,972		151,972	(134,195)	17,777			31
32	Interest			6,483,067	6,483,067		6,483,067	(6,124,210)	358,857			32
33	Real Estate Taxes			572,569	572,569		572,569	(528,599)	43,970			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			80,263	80,263		80,263		80,263			35
36	Other (specify):*											36
37	**TOTAL Ownership**			14,875,143	14,875,143		14,875,143	(13,612,746)	1,262,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	63,085	709,924	201,666	974,675		974,675		974,675			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	53,186	17,664		70,850		70,850	(70,850)				41
42	Provider Participation Fee			531,839	531,839		531,839		531,839			42
43	Other (specify):* **Marketing/HH/Me**	3,642,508	89,690	2,304,837	6,037,035		6,037,035	(6,037,035)				43
44	**TOTAL Special Cost Centers**	3,758,779	817,278	3,038,342	7,614,399		7,614,399	(6,107,885)	1,506,514			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	16,833,589	4,415,821	33,962,475	55,211,885		55,211,885	(34,631,627)	20,580,258			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: 04/01/2014 Ending: 03/31/2015

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	(26,204)	02		4
5	Telephone, TV & Radio in Resident Rooms	(231,061)	21		5
6	Rented Facility Space	(48,964)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(22,439)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,810,089)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,314,121)	32		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	(509,984)	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-	(27,176,276)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,139,138)		$	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)	(492,489)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (492,489)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (34,631,627)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Friendship Vlg Schaumburg

ID# 0023218

Report Period Beginning: 04/01/2014

Ending: 03/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Revenue	$ (2,701)	02	1
2				2
3	Gift and Coffee Shop Income	(70,850)	41	3
4	Assisted Living/lndependent Living	(2,147,100)	43	4
5	Marketing Wages	(949,275)	43	5
6	Marketing Expenses	(1,906,936)	43	6
7				7
8				8
9	Amortization of Bond Costs	(134,195)	31	9
10				10
11	Home Health Wages	(1,008,285)	43	11
12	Home Health Expenses	(25,439)	43	12
13	Misc. Income	(25,465)	21	13
14				14
15				15
16	Non-I-ICC Adjustment:			16
17	Dietary	(1,514,277)	1	17
18	Food Purchase	(926,712)	2	18
19	Housekeeping	(1,155,675)	3	19
20				20
21	Heat & Utilities	(1,684,517)	5	21
22	Maintenance	(2,673,046)	6	22
23	Administrative	(2,281,150)	17	23
24	Professional Services	(18,069)	19	24
25	Clerical & General	(104,993)	21	25
26	Employee Benefits	(2,596,461)	22	26
27	Insurance	(596,789)	26	27
28	Depreciation	(6,825,742)	30	28
29				29
30	Real Estate Taxes	(528,599)	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**	(27,176,276)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Vlg Schaumburg **#** 0023218 **Report Period Beginning:** 04/01/2014 **Ending:** 03/31/2015

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	(1,514,277)	0	0	0	0	0	0	0	0	0	0	(1,514,277)	1
2	Food Purchase	(955,617)	0	0	0	0	0	0	0	0	0	0	(955,617)	2
3	Housekeeping	(1,155,675)	0	0	0	0	0	0	0	0	0	0	(1,155,675)	3
4	Laundry	(22,439)	0	0	0	0	0	0	0	0	0	0	(22,439)	4
5	Heat and Other Utilities	(1,733,481)	0	0	0	0	0	0	0	0	0	0	(1,733,481)	5
6	Maintenance	(2,673,046)	0	0	0	0	0	0	0	0	0	0	(2,673,046)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,054,535)	0	0	0	0	0	0	0	0	0	0	(8,054,535)	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	(2,281,150)	(492,489)	0	0	0	0	0	0	0	0	0	(2,773,639)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,069)	0	0	0	0	0	0	0	0	0	0	(18,069)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(871,503)	0	0	0	0	0	0	0	0	0	0	(871,503)	21
22	Employee Benefits & Payroll Taxes	(2,596,461)	0	0	0	0	0	0	0	0	0	0	(2,596,461)	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	(596,789)	0	0	0	0	0	0	0	0	0	0	(596,789)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,363,972)	(492,489)	0	0	0	0	0	0	0	0	0	(6,856,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,418,507)	(492,489)	0	0	0	0	0	0	0	0	0	(14,910,996)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 **Report Period Beginning:** 04/01/2014 **Ending:** 03/31/2015

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	(6,825,742)	0	0	0	0	0	0	0	0	0	0	(6,825,742)	30
31	Amortization of Pre-Op. & Org.	(134,195)	0	0	0	0	0	0	0	0	0	0	(134,195)	31
32	Interest	(6,124,210)	0	0	0	0	0	0	0	0	0	0	(6,124,210)	32
33	Real Estate Taxes	(528,599)	0	0	0	0	0	0	0	0	0	0	(528,599)	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**	(13,612,746)	0	0	0	0	0	0	0	0	0	0	(13,612,746)	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	(70,850)	0	0	0	0	0	0	0	0	0	0	(70,850)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,037,035)	0	0	0	0	0	0	0	0	0	0	(6,037,035)	43
44	**TOTAL Special Cost Centers**	(6,107,885)	0	0	0	0	0	0	0	0	0	0	(6,107,885)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,139,138)	(492,489)	0	0	0	0	0	0	0	0	0	(34,631,627)	45

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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

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 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	$ 3,818,628	Friendship Village Executive/Corporate Allocation		$ 3,326,139	$ (492,489)	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			$ 3,818,628			$ 3,326,139	$ * (492,489)	14

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

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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: 04/01/2014 Ending: 3/31/2015

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 [X] NO [ ]

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

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: ( )

	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	Dietary	Meals Ratio	423,908	2	$ 3,504,186	$ 1,985,743	240,723	$ 1,989,909	1
2	2	Food Purchase	Meals Ratio	423,908	2	2,144,502	0	240,723	1,217,790	2
3	3	Housekeeping	Square Feet	737,530	2	1,251,806	1,067,443	56,638	96,131	3
4	4	Laundry	Pounds	1,076,536	2	350,474	261,269	1,007,611	328,035	4
5	5	Heat & Utilities	Square Feet	737,530	2	1,824,639	0	56,638	140,122	5
6	6	Maintenance	Square Feet	737,530	2	2,895,396	1,576,109	56,638	222,350	6
7	7	Other (disposal, waste)	Square Feet	737,530	2	0	0	56,638	0	7
8	17	Administrative	Employee Ratio	457	2	3,818,628	0	184	1,537,478	8
9	19	Professional Services	Square Feet	737,530	2	19,572	0	56,638	1,503	9
10	21	Clerical & General	Employee Ratio	457	2	175,757	0	184	70,764	10
11	22	Employee Benefits	Employee Ratio	457	2	4,346,456	0	184	1,749,995	11
12	26	Insurance	Square Feet	737,530	2	646,431	0	56,638	49,642	12
13	30	Depreciation	Actual	7,587,272	2	7,587,272	0	761,530	761,530	13
14	32	Interest	Square Feet	737,530	2	4,672,978	0	56,638	358,857	14
15	33	Real Estate Taxes	Square Feet	737,530	2	572,569	0	56,638	43,970	15
16										16
17							528,599			17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,810,666	$ 5,419,163		$ 8,568,076	25

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Revenue Bond Series 2005		X	Bond Issuance			$ 80,500,000	$ 71,715,619		Variable	$ 4,045,304	1
2	Revenue Bond Series 2010		X	Bond Issuance			33,610,000	33,144,620		Variable	2,426,463	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 114,110,000	$ 104,860,239			$ 6,471,767	9
	B. Non-Facility Related*											
10	Investment Income											10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 114,110,000	$ 104,860,239			$ 6,471,767	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.)**

Facility Name & ID Number Friendship Vlg Schaumburg **#** 0023218 **Report Period Beginning:** 04/01/2014 **Ending:** 03/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 519,869	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.)		$ 374,201	2
3. Under or (over) accrual (line 2 minus line 1).		$ (145,668)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 718,237	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.		$ 572,569	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	593,438	8
	2011	507,365	9
	2012	472,710	10
	2013	565,090	11
	2014	613,175	12

	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.

Friendship Village Schaumburg
3/31/2015
RE Tax Reconcilation

	BEGINNING BALANCE	ACCRUAL	ADJUSTMENT/ REFUND	PAYMENT	DESCRIPTION	ENDING BALANCE
4/30/2014	#########	(35,189.00)				(555,058.39)
5/31/2014	#########	(35,189.00)		1,368.45	Kane County 2013 1st Installment	(588,878.94)
6/30/2014	#########	(35,189.00)				(624,067.94)
7/31/2014	#########	(35,189.00)		371,464.07	2013 Cook 2nd installment	(287,792.87)
8/31/2014	#########	(35,189.00)		1,368.45	Kane County 2013 2nd Installment	(321,613.42)
9/30/2014	#########	(35,189.00)				(356,802.42)
10/31/2014	#########	(55,189.00)				(411,991.42)
11/30/2014	#########	(55,189.00)				(467,180.42)
12/31/2014	#########	(55,189.00)				(522,369.42)
1/31/2015	#########	(55,189.00)				(577,558.42)
2/28/2015	#########	(67,921.21)				(645,479.63)
3/31/2015	#########	(72,758.23)				(718,237.86)
						TB 10-00-00-2230-00
		(572,569.44)	-	374,200.97		
		TB 10-01-98-9600-00				

2014 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 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.	07-22-100-026-0000	Long Term Care Property	$ 603,690.13	$ 46,359.88
2.	07-22-101-042-0000	Long Term Care Property	$ 6,539.39	$ 502.19
3.	02-08-401-018	Long Term Care Property	$ 2,945.34	$ 226.18
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 613,174.86	$ 47,088.25

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 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.

Friendship Village Schaumburg
3/31/2015
RE Tax Allocation

Tax Index Number	Property Description		Total Tax	Tax Applicable to Nursing Home
07-22-100-026-0000	Long Term Care Property	$	603,690	46,360
07-22-101-042-0000	Long Term Care Property	$	6,539	502
02-08-401-018	Long Term Care Property	$	2,945	226

Allocation Calculation

	Facility Units	Total Units	% Applicable to Nursing Home
Page 8 Square Feet	56,638	737,530	8%

Tax ID	Total Tax	Allocation %	Tax Applicable to Nursing Home (Total Tax * Allocation %)
07-22-100-026-0000	603,690	8%	46,360
07-22-101-042-0000	6,539	8%	502
02-08-401-018	2,945	8%	226

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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? [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).

Bridgegate Apartments - Independent Living Apartments - Buildings Separate From SNF
Bridgewater Place Apartment Homes - Independent Living Apartment Home - Buildings Separate From SNF
Crosswell Terrace Garden Homes - Independent Living Homes - Buildings Separate From SNF
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 [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	SNF	Approx. 50	1977	$ 132,065	1
2	Non-Allowable			4,392,192	2
3	TOTALS	#VALUE!		$ 4,524,257	3

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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	180		1977	1977	$ 1,760,825	$ 41,884	40	$ 41,884	$	$	4
5	10		1993	1993	1,102,771	31,557	40	31,557			5
6	60		1998	1998	2,934,069	73,352	40	73,352			6
7											7
8											8
	Improvement Type**										
9	1994 Fixed Assets			1994	174,574		Various				9
10	1995 Fixed Assets			1995	148,003		Various				10
11	1997 Fixed Assets			1997	470,386		Various				11
12	1998 Fixed Assets			1998	135,637		Various				12
13	1999 Fixed Assets			1999	134,210		Various				13
14	2000 Fixed Assets			2000	33,116		Various				14
15	2002 Fixed Assets			2002	27,260		Various				15
16	2003 Fixed Assets			2003	7,395		Various				16
17	2005 Fixed Assets			2005	131,485		Various				17
18	2006 Fixed Assets			2006	619,989		Various				18
19	Gazebo Landscaping			2008	3,348		20				19
20	HCC Gazebo Replacement			2008	26,460		10				20
21	HCC Special Care Phase II Design Cost Only			2008	74,919		10				21
22	HCC Special Care Phase II Renovation			2008	174,683		10				22
23	Parking Garage			2010	21,766		10				23
24	Briarwood Anti-Elopement Door			2010	130,985		15				24
25	Associate Store Renovation			2010	4,499		15				25
26	Contrete work in Gazebo courtyard			2011	4,070		15				26
27	Special Care Awning			2011	4,850		5				27
28	"E" Supply Room			2011	3,362		15				28
29	"F" Supply Room			2011	3,589		15				29
30	Bridgegate Garage Door Replacements			2012	4,650		15				30
31	Replace 4 External Doors in Health Center			2012	5,060		10				31
32	Renovations of Pavilion E & F			2013	2,004,128		20				32
33	IDPH Life Safety Survey Plan of Correction			2014	38,745		15				33
34											34
35	Financial Statement Depreciation					198,348		198,348		5,202,850	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 Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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	$ 2,713,277	$ 402,901	$ 402,901	$	Var	$ 1,296,651	71
72	Current Year Purchases	217,297	13,488	13,488		Var	13,488	72
73	Fully Depreciated Assets	646,101				Var	646,101	73
74								74
75	TOTALS	$ 3,576,675	$ 416,389	$ 416,389	$		$ 1,956,240	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	$ 20,852	76
77		Pick-up Truck	2005	18,259				5	18,249	77
78										78
79										79
80	TOTALS			$ 39,111	$	$	$		$ 39,101	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)	$ 18,324,877	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 761,530	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 761,530	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)	$ 7,198,191	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	$ 2,082,276	$ 70,920	$ 1,860,319	86
87	AL/IL/HH	68,688,399	3,663,378	48,912,328	87
88	Bridgewater	84,559,664	2,562,805	18,391,566	88
89	Friendship Center/MillCreek	5,850,356	147,089	1,100,947	89
90	Beauty Shop/Clinic/Commons/Dining/La	6,114,997	381,541	4,060,255	90
91	TOTALS	$ 167,295,692	$ 6,825,733	$ 74,325,415	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: 04/01/2014 Ending: 03/31/2015

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 80,263 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.

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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 ____

No CNA training took place at the facility, all training was completed off-site.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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	10a-3	hrs	$	5,859	$ 450,230	$	5,859	$ 450,230	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		9,520	763,679		9,520	763,679	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,185	196,155		2,185	196,155	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				709,924		709,924	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			$	17,564	$ 1,410,064	$ 709,924	17,564	$ 2,119,988	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 # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2015 (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	$ 6,660,873	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 732,995)	7,298,621		3
4	Supply Inventory (priced at cost)	139,718		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	33,591		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	8,972,243		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 23,105,046	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,957,520		12
13	Land	4,524,257		13
14	Buildings, at Historical Cost	119,280,491		14
15	Leasehold Improvements, at Historical Cost	47,442,156		15
16	Equipment, at Historical Cost	14,354,075		16
17	Accumulated Depreciation (book methods)	(81,533,796)		17
18	Deferred Charges	1,094,924		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): See Attached Schedule	4,785,830		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 130,905,457	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 154,010,503	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 11,114,288	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,461,901		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,995		31
32	Accrued Real Estate Taxes(Sch.IX-B)	718,237		32
33	Accrued Interest Payable	771,890		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	296,313		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 14,364,624	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	104,860,239		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	95,716,496		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 200,576,735	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 214,941,359	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (60,930,856)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 154,010,503	$	48

***(See instructions.)**

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (56,773,487)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (56,773,487)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,157,366)	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)**	$ (4,157,369)	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)**	$ (60,930,856)	24	*

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

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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	$ 23,002,814	1
2	Discounts and Allowances for all Levels	(1,518,261)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,484,553	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	440,032	6
7	Oxygen	73,305	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 513,337	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	113,899	12
13	Barber and Beauty Care	13,661	13
14	Non-Patient Meals	41,706	14
15	Telephone, Television and Radio	231,061	15
16	Rental of Facility Space	48,964	16
17	Sale of Drugs	53,142	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,869	19
20	Radiology and X-Ray		20
21	Other Medical Services	385,580	21
22	Laundry	35,700	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 950,582	23
	D. Non-Operating Revenue		
24	Contributions	61,103	24
25	Interest and Other Investment Income***	1,173,512	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,234,615	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	IL/AL/HH Revenue	26,845,967	28
28a	Other Revenue	25,465	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,871,432	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 51,054,519	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	11,971,003	31
32	Health Care	10,913,633	32
33	General Administration	9,837,707	33
	B. Capital Expense		
34	Ownership	14,875,143	34
	C. Ancillary Expense		
35	Special Cost Centers	7,082,560	35
36	Provider Participation Fee	531,839	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 55,211,885	40
41	**Income before Income Taxes (line 30 minus line 40)****	(4,157,366)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (4,157,366)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,111,312	44
45	Private Pay - Net Inpatient Revenue	1,235,752	45
46	Medicare - Net Inpatient Revenue	8,607,974	46
47	Other-(specify) Hospice/Life Care	7,529,515	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 21,484,553	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: 04/01/2014 Ending: 03/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,808	2,080	$ 104,292	$ 50.14	1
2	Assistant Director of Nursing	6,664	7,392	289,166	39.12	2
3	Registered Nurses	83,700	91,389	2,914,079	31.89	3
4	Licensed Practical Nurses	13,919	15,723	451,471	28.71	4
5	CNAs & Orderlies	181,657	199,227	2,949,454	14.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,618	9,667	277,859	28.74	8
9	Activity Director					9
10	Activity Assistants	11,068	12,251	250,441	20.44	10
11	Social Service Workers	30,061	32,545	446,761	13.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	126,974	136,982	1,712,079	12.50	15
16	Dishwashers	24,235	26,196	274,931	10.50	16
17	Maintenance Workers	82,322	91,189	1,611,120	17.67	17
18	Housekeepers	86,853	96,380	1,129,576	11.72	18
19	Laundry	19,758	21,722	259,736	11.96	19
20	Administrator	1,840	2,080	136,951	65.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	13,904	15,491	227,725	14.70	31
32	Other Health C: AL/IL/HH	141,033	154,456	2,704,613	17.51	32
33	Other(specify) Mrktg/Store	31,081	34,884	1,093,335	31.34	33
34	TOTAL (lines 1 - 33)	865,495	949,654	$ 16,833,589 *	$ 17.73	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	27,750	9-3	36
37	Medical Records Consultant	Monthly	1,600	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,191	10-3	39
40	Physical Therapy Consultant	2,185	196,155	10a-3	40
41	Occupational Therapy Consultant	5,859	450,230	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9,520	763,679	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dietary Outside Labor	Monthly	375,421	1-03	47
48					48
49	TOTAL (lines 35 - 48)	17,564	$ 1,830,026		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	16	719	10-3	51
52	Certified Nurse Assistants/Aides	993	24,727	10-3	52
53	TOTAL (lines 50 - 52)	1,009	$ 25,446		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Madl	Administrator of HC		$ 136,951
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,951

B. Administrative - Other

Description	Amount
Management Fees FSO	$ 3,818,628
TOTAL (agree to Schedule V, line 17, col. 3)	$ 3,818,628
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Atlas & Leviton	Legal	$ 19,572
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 19,572

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	1,206,983
Employee Health Insurance	255,728
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Vaccinations	8,271
Employee Programs	38,758
Transfer from Corporate	2,836,716
Less: Non-reimburseable Benefits	(2,596,461)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,749,995

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	33,951
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 651	10,427
Subscriptions and Publications	9,257
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,635

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,923
Seminar Expense	23,260
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 36,183

**See instructions.

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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													
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11													
12													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Friendship Vlg Schaumburg # 0023218 Report Period Beginning: 04/01/2014 Ending: 03/31/2015

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 $33,702 CARF $8,650**

(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. $ **117,927** 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. $ **531,839**
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** 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. $ **26,204**

(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.