FOR BHF USE								

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Care

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

County: Washington

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

HFS ID Number:

Date of Initial License for Current Owners: 11/1/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Rhonda Houchens Telephone Number: (270) 726-4033
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Rhonda Houchens, Client Manager
	(Firm Name & Address)	Hargis & Associates, LLC PO Box 263 Russellville, KY 42276
	(Telephone)	(270) 726-4033 Fax # (270) 726-8069

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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	150	Skilled (SNF)	150	54,900	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	150	TOTALS	150	54,900	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	12,950	13,562	5,100	31,612	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,950	13,562	5,100	31,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.58%

D. How many bed-hold days during this year were paid by the Department?
1 (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 2,232

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: 12/31/2016 Fiscal Year: 12/31/2016

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

STATE OF ILLINOIS

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	263,896	15,126	6,709	285,731		285,731		285,731			1
2	Food Purchase		199,132		199,132		199,132	(423)	198,709			2
3	Housekeeping	227,996	22,369		250,365		250,365		250,365			3
4	Laundry	78,878	18,040		96,918		96,918		96,918			4
5	Heat and Other Utilities			213,378	213,378		213,378	(11,897)	201,481			5
6	Maintenance	93,636	1,071	55,829	150,536	250	150,786		150,786			6
7	Other (specify):* Infectious Waste			4,864	4,864		4,864		4,864			7
8	TOTAL General Services	664,406	255,738	280,780	1,200,924	250	1,201,174	(12,320)	1,188,854			8
	B. Health Care and Programs											
9	Medical Director			20,100	20,100		20,100		20,100			9
10	Nursing and Medical Records	1,757,852	69,413	128,558	1,955,823	14,366	1,970,189		1,970,189			10
10a	Therapy											10a
11	Activities	66,436	4,082	8,134	78,652		78,652	(2,179)	76,473			11
12	Social Services	94,724	55	79	94,858	(11,716)	83,142		83,142			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,919,012	73,550	156,871	2,149,433	2,650	2,152,083	(2,179)	2,149,904			16
	C. General Administration											
17	Administrative	91,458		310,000	401,458		401,458	(147,000)	254,458			17
18	Directors Fees											18
19	Professional Services			54,670	54,670	(14,581)	40,089		40,089			19
20	Dues, Fees, Subscriptions & Promotions			35,832	35,832	132	35,964	(15,209)	20,755			20
21	Clerical & General Office Expenses	96,198	15,893	39,920	152,011	83	152,094	39,593	191,687			21
22	Employee Benefits & Payroll Taxes			466,579	466,579		466,579	80,300	546,879			22
23	Inservice Training & Education			2,786	2,786		2,786		2,786			23
24	Travel and Seminar			250	250	(250)						24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			120,723	120,723		120,723		120,723			26
27	Other (specify):*											27
28	TOTAL General Administration	187,656	15,893	1,030,760	1,234,309	(14,616)	1,219,693	(42,316)	1,177,377			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,771,074	345,181	1,468,411	4,584,666	(11,716)	4,572,950	(56,815)	4,516,135			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **Friendship Manor Health Care** **#0050161** **Report Period Beginning:** **01/01/2016** **Ending:** **12/31/2016**

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			193,913	193,913		193,913	20,147	214,060			30
31	Amortization of Pre-Op. & Org.			36,934	36,934		36,934	(36,934)				31
32	Interest			247,765	247,765		247,765	(71,138)	176,627			32
33	Real Estate Taxes			78,440	78,440		78,440		78,440			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			212	212		212		212			35
36	Other (specify):*											36
37	**TOTAL Ownership**			557,264	557,264		557,264	(87,925)	469,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,249	3,249		3,249		3,249			38
39	Ancillary Service Centers		79,971	317,546	397,517		397,517		397,517			39
40	Barber and Beauty Shops		276		276		276		276			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,668	247,668		247,668		247,668			42
43	Other (specify):* **Marketing**					11,716	11,716	(11,716)				43
44	**TOTAL Special Cost Centers**		80,247	568,463	648,710	11,716	660,426	(11,716)	648,710			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,771,074	425,428	2,594,138	5,790,640		5,790,640	(156,456)	5,634,184			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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				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	20,147	30		9
10	Interest and Other Investment Income	(9,487)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(423)	02		13
14	Non-Care Related Interest	(61,651)	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	(4,788)	21		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	(10,113)	21		24
25	Fund Raising, Advertising and Promotional	(15,209)	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	(64,332)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (145,856)		$	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)	(10,600)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,600)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (156,456)		37

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

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

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

Friendship Manor Health Care

ID# 0050161

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (1,606)	21	1
2	Flowers	(2,179)	11	2
3	Plant Cable	(11,897)	05	3
4	Amortization	(36,934)	31	4
5	Marketing Salary	(11,716)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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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**	(64,332)		49

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(423)	0	0	0	0	0	0	0	0	0	0	(423)	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	(11,897)	0	0	0	0	0	0	0	0	0	0	(11,897)	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**	(12,320)	0	0	0	0	0	0	0	0	0	0	(12,320)	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	(2,179)	0	0	0	0	0	0	0	0	0	0	(2,179)	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**	(2,179)	0	0	0	0	0	0	0	0	0	0	(2,179)	16
	C. General Administration													
17	Administrative	0	(147,000)	0	0	0	0	0	0	0	0	0	(147,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(15,209)	0	0	0	0	0	0	0	0	0	0	(15,209)	20
21	Clerical & General Office Expenses	(16,507)	56,100	0	0	0	0	0	0	0	0	0	39,593	21
22	Employee Benefits & Payroll Taxes	0	80,300	0	0	0	0	0	0	0	0	0	80,300	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**	(31,716)	(10,600)	0	0	0	0	0	0	0	0	0	(42,316)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,215)	(10,600)	0	0	0	0	0	0	0	0	0	(56,815)	29

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	20,147	0	0	0	0	0	0	0	0	0	0	20,147	30
31	Amortization of Pre-Op. & Org.	(36,934)	0	0	0	0	0	0	0	0	0	0	(36,934)	31
32	Interest	(71,138)	0	0	0	0	0	0	0	0	0	0	(71,138)	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**	(87,925)	0	0	0	0	0	0	0	0	0	0	(87,925)	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):*	(11,716)	0	0	0	0	0	0	0	0	0	0	(11,716)	43
44	**TOTAL Special Cost Centers**	(11,716)	0	0	0	0	0	0	0	0	0	0	(11,716)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(145,856)	(10,600)	0	0	0	0	0	0	0	0	0	(156,456)	45

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
Jay Frances	50					
Kimberly Smith	50					

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	$ 310,000	Legacy Health Systems	100.00%	$	$ (310,000)	1
2	V	17	Salaries		Legacy Health Systems		163,000	163,000	2
3	V	22	Taxes & Insurances		Legacy Health Systems		80,300	80,300	3
4	V	21	Telephone		Legacy Health Systems		11,200	11,200	4
5	V	21	Travel		Legacy Health Systems		37,400	37,400	5
6	V	21	Office Supplies		Legacy Health Systems		7,500	7,500	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 310,000			$ 299,400	$ * (10,600)	14

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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14								14
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16								16
17								17
18								18
19								19
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25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$27,906.57	11/1/08	$ 2,187,000	$ 3,673,680	11/1/28	4.5000	$ 173,933	1
2	Loan from Previous Owner		X	Mortgage Payable	$7,407.84	11/1/08	667,250	160,570	11/1/18	6.0000	12,181	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,314.41		$ 2,854,250	$ 3,834,250			$ 186,114	9
	B. Non-Facility Related*											
10	Interest Income		X								(1)	10
11	Interest Income	X									(9,486)	11
12	N/P- D. Frances	X		Buyout 33% of ownership	$8,249.45	1/1/16	1,250,000	1,212,659	1/1/36	5.0000	61,651	12
13												13
14	TOTAL Non-Facility Related				$8,249.45		$ 1,250,000	$ 1,212,659			$ 52,164	14
15	TOTALS (line 9+line14)						$ 4,104,250	$ 5,046,909			$ 238,278	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 2015 report.	$	83,236	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.)	$	80,838	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,398)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	80,838	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.	$	78,440	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2011	81,619	8
2012	81,818	9
2013	83,460	10
2014	83,236	11
2015	80,838	12

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor Health Care COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0050161

CONTACT PERSON REGARDING THIS REPORT Rhonda Houchens

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

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	10-12-23-251-007	Long Term Care Property	$ 1,026.70	$ 1,026.70
2.	10-12-23-251-008	Long Term Care Property	$ 77,569.70	$ 77,569.70
3.	10-12-23-254-001	Long Term Care Property	$ 545.40	$ 545.40
4.	10-12-23-254-002	Long Term Care Property	$ 545.40	$ 545.40
5.	10-12-23-256-003	Long Term Care Property	$ 130.50	$ 130.50
6.	10-12-23-276-005	Long Term Care Property	$ 245.60	$ 245.60
7.	10-12-23-279-005	Long Term Care Property	$ 774.88	$ 774.88
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 80,838.18	$ 80,838.18

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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).

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2008	$ 211,500	1
2					2
3	TOTALS			$ 211,500	3

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 793,318	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	248,035		20	12,265	12,265	98,118	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Roof Project-Wing 4	2010	$ 57,268	$	20	$ 2,863	$ 2,863	$ 20,043	37
38	Sprinkler	2010	4,790		20	240	240	1,678	38
39	2 Water Heaters	2010	2,683		20	134	134	939	39
40	Holland Const/Aci Arch	2010	4,937		20	632	632	4,425	40
41	New Doors	2010	20,473		20	1,024	1,024	7,167	41
42	New Doors	2011	7,360		20	736	736	4,416	42
43	HVAC Repairs	2011	4,414		20	441	441	2,647	43
44	Front Entrance Demolition, Millwork, Walls, Ceilings, Flooring	2011	34,675		20	1,734	1,734	10,403	44
45	New Roof	2011	5,899		20	590	590	3,540	45
46	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	1,914	46
47	Roof Repair	2011	3,100		20	155	155	930	47
48	Soffit & Fascia	2012	13,148		20	657	657	3,286	48
49	Two Bryant Rooftop A/Cs	2012	10,525		20	526	526	2,631	49
50	Sewer Line Replacement	2012	15,160		20	758	758	3,790	50
51	Kitchen Tile	2012	3,765		20	188	188	941	51
52	Soffit & Fascia	2012	4,183		20	209	209	1,045	52
53	Installation of 6" Seamless Guttering	2013	12,782		20	639	639	2,556	53
54	Installation of Walk in cooler	2013	8,460		20	423	423	1,692	54
55	Installation of Walk in Freezer	2013	9,130		20	457	457	1,828	55
56	Roof Replacement	2013	141,706		20	7,085	7,085	28,340	56
57	2 Carrier Ductless Heat Pumps	2013	6,975		20	349	349	1,396	57
58	Concrete Resurfacing	2013	5,590		20	280	280	1,120	58
59	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	1,872	59
60	Dmt Gas Genrator #54	2013	6,000		20	300	300	1,200	60
61	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	8,324	61
62	Rooftop AC unit	2014	5,355		10	536	536	1,390	62
63	Rebate on Installation of High Efficiency Lighting	2014	(18,266)		20	(913)	(913)	(2,739)	63
64	High Efficiency Lighting	2015	14,117		20	706	706	1,334	64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			191,431			(191,431)		69
70	TOTAL (lines 4 thru 69)		$ 4,478,121	$ 191,431		$ 133,023	$ (58,408)	$ 1,009,544	70

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 785,549	$	$ 78,555	$ 78,555	10	$ 632,598	71
72	Current Year Purchases	16,837	1,169	1,169		10	1,169	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 802,386	$ 1,169	$ 79,724	$ 78,555		$ 633,767	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	$ 1,313	$ 1,313	$	5	$ 2,298	76
77										77
78										78
79										79
80	TOTALS			$ 6,564	$ 1,313	$ 1,313	$		$ 2,298	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)	$ 5,498,571	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,913	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 214,060	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,147	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,645,609	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.

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 212 Description: See attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 122,739	$		$ 122,739	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			40,815			40,815	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03/02	hrs			119,642	1,115		120,757	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				76,901		76,901	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	39-03/02				34,350	1,955		36,305	13
14	TOTAL			$		$ 317,546	$ 79,971		$ 397,517	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 43,379	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,724,881		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,611		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	274,107		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,058,978	$	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	4,422,288		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	853,209		16
17	Accumulated Depreciation (book methods)	(2,065,792)		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):	249,271		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,671,312	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,730,290	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 346,706	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	193,994		29
30	Accrued Salaries Payable	131,985		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,705		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		105,959		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 856,349	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,180,555		39
40	Mortgage Payable	3,834,250		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)**	$ 6,014,805	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,871,154	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,140,864)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,730,290	$	48

*(See instructions.)

Facility Name & ID Number Friendship Manor Health Care **#** 0050161 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 817,115	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 817,115	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(670,979)	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	(1,287,000)	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)**	$ (1,957,979)	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)**	$ (1,140,864)	24 *

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

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 4,436,869	1
2	Discounts and Allowances for all Levels	(361,916)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,074,953	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	836,480	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 836,480	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	69,938	19
20	Radiology and X-Ray	3,327	20
21	Other Medical Services	42,240	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 198,741	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,487	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,487	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)**	$ 5,119,661	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,200,924	31
32	Health Care	2,149,738	32
33	General Administration	1,234,309	33
	B. Capital Expense		
34	Ownership	557,264	34
	C. Ancillary Expense		
35	Special Cost Centers	648,405	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,790,640	40
41	**Income before Income Taxes (line 30 minus line 40)****	(670,979)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (670,979)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,815,411	44
45	Private Pay - Net Inpatient Revenue	1,779,221	45
46	Medicare - Net Inpatient Revenue	123,392	46
47	Other-(specify) **Private Insurance**	87,691	47
48	Other-(specify) **Hospice**	269,238	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,074,953	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 Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	1,832	2,120	$ 76,036	$ 35.87	1
2	Assistant Director of Nursing	553	633	15,003	23.70	2
3	Registered Nurses	11,653	13,018	308,682	23.71	3
4	Licensed Practical Nurses	25,704	28,773	547,626	19.03	4
5	CNAs & Orderlies	65,565	70,532	780,345	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,612	6,112	66,436	10.87	10
11	Social Service Workers	3,777	4,325	83,008	19.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,277	22,380	263,896	11.79	15
16	Dishwashers					16
17	Maintenance Workers	4,046	4,290	93,636	21.83	17
18	Housekeepers	16,765	18,566	227,996	12.28	18
19	Laundry	6,714	7,811	78,878	10.10	19
20	Administrator	1,743	2,067	91,458	44.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,840	4,336	96,198	22.19	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	1,922	2,106	30,160	14.32	31
32	Other Health Care(specify)					32
33	Other(specify)	500	520	11,716	22.53	33
34	TOTAL (lines 1 - 33)	170,503	187,589	$ 2,771,074 *	$ 14.77	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	132	$ 6,437	01-03	35
36	Medical Director	192	20,100	09-03	36
37	Medical Records Consultant	16	1,000	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	65	4,986	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	441	$ 35,523		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	5,410	118,755	10-03	52
53	TOTAL (lines 50 - 52)	5,410	$ 118,755		53

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Leitz	Administrator	0	$ 91,458
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 91,458

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	$ 432
Hargis & Associates	Accounting	900
Calhoun & Company	Accounting	1,565
Abacus Paysystems	Payroll Processing	5,491
Paycor	Payroll Processing	8,882
Pointclickcare	Computer Services	20,487
Casamba	Computer Services	2,950
Asher Business Services	Computer Services	544
Safe Mode	Computer Services	3,725
Mckesson Medical	Computer Services	3,852
Haertling Radio Shack	Computer Services	277
Supplemental Page		5,565
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 54,670

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,715
Unemployment Compensation Insurance	
FICA Taxes	247,110
Employee Health Insurance	149,397
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	9,657
TOTAL (agree to Schedule V, line 22, col.8)	$ 546,879

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	13,069
Health Care Worker Background Check (Indicate # of checks performed 84)	1,334
Patient Background Checks 57	560
Due&Subscriptions	477
License & Fees	4,715
Professional Fees	600
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,755

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number **Friendship Manor Health Care** **# 0050161** **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

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. ______

(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? **150**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,584** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ______ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ______ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
______

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **247,668**
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