FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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:** 0042846

Facility Name: Friendship Skilled Nsg & Rehab

Address: 826 North High St (Number) Carlinville (City) 62626 (Zip Code)

County: Macoupin

Telephone Number: (217)854-9606 **Fax #** (217)854-8484

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1997

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Carol Sparks **Telephone Number:** (949)349-1222
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 01/01/17 to 12/31/17 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) Chris Joos, Partner
(Firm Name & Address) Plante & Moran, PLLC, 250 S. High Street, Suite 100
(Telephone) (614)222-9040 Fax # (248)233-8811

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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49.00	Skilled (SNF)	49	17,885	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	49	TOTALS	49	17,885	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	5,478	4,582	1,361	11,421	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,478	4,582	1,361	11,421	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.86%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 3/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 1,233

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	76,983	5,095	6,056	88,134		88,134		88,134			1
2	Food Purchase		52,067		52,067		52,067		52,067			2
3	Housekeeping	29,963	3,222	5,142	38,327		38,327		38,327			3
4	Laundry	20,265	2,813		23,078		23,078		23,078			4
5	Heat and Other Utilities			53,974	53,974		53,974		53,974			5
6	Maintenance	17,181	8,748	11,716	37,645		37,645		37,645			6
7	Other (specify):* Trash & Refuse			1,361	1,361		1,361		1,361			7
8	**TOTAL General Services**	144,392	71,945	78,249	294,586		294,586		294,586			8
	B. Health Care and Programs											
9	Medical Director			6,985	6,985		6,985		6,985			9
10	Nursing and Medical Records	671,887	20,490	4,242	696,619		696,619		696,619			10
10a	Therapy			239,103	239,103		239,103	(9,061)	230,042			10a
11	Activities	25,850	3,117	1,392	30,359		30,359		30,359			11
12	Social Services	19,683		547	20,230		20,230		20,230			12
13	CNA Training											13
14	Program Transportation			8,291	8,291		8,291		8,291			14
15	Other (specify):*							10,313	10,313			15
16	**TOTAL Health Care and Programs**	717,420	23,607	260,560	1,001,587		1,001,587	1,252	1,002,839			16
	C. General Administration											
17	Administrative	55,330		112,254	167,584		167,584	(2,093)	165,491			17
18	Directors Fees											18
19	Professional Services			37,897	37,897		37,897	(184)	37,713			19
20	Dues, Fees, Subscriptions & Promotions			7,671	7,671		7,671	(941)	6,730			20
21	Clerical & General Office Expenses	47,164	12,614	67,565	127,343		127,343	(44,869)	82,474			21
22	Employee Benefits & Payroll Taxes			190,261	190,261		190,261		190,261			22
23	Inservice Training & Education											23
24	Travel and Seminar			832	832		832		832			24
25	Other Admin. Staff Transportation			145	145		145		145			25
26	Insurance-Prop.Liab.Malpractice			106,218	106,218		106,218		106,218			26
27	Other (specify):* Contract Admnstr			43,854	43,854		43,854	(13,800)	30,054			27
28	**TOTAL General Administration**	102,494	12,614	566,697	681,805		681,805	(61,887)	619,918			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	964,306	108,166	905,506	1,977,978		1,977,978	(60,635)	1,917,343			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 Skilled Nsg & Rehab #0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			12,154	12,154		12,154	73,731	85,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							65,518	65,518			32
33	Real Estate Taxes			19,152	19,152		19,152	(299)	18,853			33
34	Rent-Facility & Grounds			140,840	140,840		140,840	(139,190)	1,650			34
35	Rent-Equipment & Vehicles			31,593	31,593		31,593		31,593			35
36	Other (specify):* Business Taxes			135	135		135	(135)				36
37	TOTAL Ownership			203,874	203,874		203,874	(375)	203,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	5,452	2,232	47,479	55,163		55,163		55,163			39
40	Barber and Beauty Shops			166	166		166		166			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,379	88,379		88,379		88,379			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	5,452	2,232	136,024	143,708		143,708		143,708			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	969,758	110,398	1,245,404	2,325,560		2,325,560	(61,010)	2,264,550			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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		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				9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,090)	21		24
25	Fund Raising, Advertising and Promotional	(13,124)	27		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	(4,014)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,235)		$	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)	8,286	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 8,286		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (51,949)		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 Skilled Nsg & Rehab

ID# 0042846

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Bank Charges	(412)	21	3
4	Collection Agency Fees	(676)	27	4
5	Business Taxes	(135)	36	5
6	Patient Theft and Loss	(87)	21	6
7	Prior Year Expense	(1,226)	21	7
8	Nonallowable PAC Dues	(941)	20	8
9	Nonallowable Legal Fees	(184)	19	9
10	Real Estate Taxes	(299)	33	10
11	Fines & Penalties	(54)	21	11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(4,014)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Skilled Nsg & Rehab **#** 0042846 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	10,313	0	0	0	0	0	0	0	10,313	15
16	**TOTAL Health Care and Programs**	0	0	0	10,313	0	0	0	0	0	0	0	10,313	16
	C. General Administration													
17	Administrative	0	0	0	(2,093)	0	0	0	0	0	0	0	(2,093)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(184)	0	0	0	0	0	0	0	0	0	0	(184)	19
20	Fees, Subscriptions & Promotions	(941)	0	0	0	0	0	0	0	0	0	0	(941)	20
21	Clerical & General Office Expenses	(44,869)	0	0	0	0	0	0	0	0	0	0	(44,869)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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):* **See 5a**	(13,800)	0	0	0	0	0	0	0	0	0	0	(13,800)	27
28	**TOTAL General Administration**	(59,794)	0	0	(2,093)	0	0	0	0	0	0	0	(61,887)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,794)	0	0	8,220	0	0	0	0	0	0	0	(51,574)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	0	63,333	0	10,398	0	0	0	0	0	0	0	73,731	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7)	0	0	65,525	0	0	0	0	0	0	0	65,518	32
33	Real Estate Taxes	(299)	0	0	0	0	0	0	0	0	0	0	(299)	33
34	Rent-Facility & Grounds	0	(139,190)	0	0	0	0	0	0	0	0	0	(139,190)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* **Business Tax**	(135)	0	0	0	0	0	0	0	0	0	0	(135)	36
37	**TOTAL Ownership**	(441)	(75,857)	0	75,923	0	0	0	0	0	0	0	(375)	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	(9,061)	0	0	0	0	0	0	0	0	(9,061)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(9,061)	0	0	0	0	0	0	0	0	(9,061)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,235)	(75,857)	(9,061)	84,143	0	0	0	0	0	0	0	(61,010)	45

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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		34	Rent	$ 139,190	Covenant Care Carlinville, LLC	100.00%	$	$ (139,190)	1
2	V		30	Depreciation		Covenant Care Carlinville, LLC	100.00%	63,333	63,333	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				$ 139,190			$ 63,333	$ * (75,857)	14

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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)	
15	V	39	Physical Therapy	$ 74,118	Affirma Rehabilitation	100.00%	$ 71,309	$ (2,809)	15
16	V	39	Occupational Therapy	137,124	Affirma Rehabilitation	100.00%	131,928	(5,196)	16
17	V	39	Speech Therapy	27,861	Affirma Rehabilitation	100.00%	26,805	(1,056)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 239,103			$ 230,042	$ * (9,061)	39

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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)	
15	V	17	Indirect Care	$	Covenant Care California, LLC	100.00%	$ 110,161	$ 110,161	15
16	V	15	Direct Care		Covenant Care California, LLC	100.00%	10,313	10,313	16
17	V	32	Capital - Interest		Covenant Care California, LLC	100.00%	65,525	65,525	17
18	V	30	Capital - Depreciation		Covenant Care California, LLC	100.00%	10,398	10,398	18
19	V	17	Management Fees	112,254	Covenant Care California, LLC	100.00%		(112,254)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 112,254			$ 196,397	$ * 84,143	39

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	COVENANT CARE CALIFORNIA, LLC	100.00%	ARBOR NURSING CENTER	CALIFORNIA	COVENANT CARE C	ALISO VIEJO, CA	MANAGEMENT C	1
2			ARBOR PLACE	CALIFORNIA	AFFIRMA REHABIL	ALISO VIEJO, CA	THERAPY	2
3			BUENA VISTA CARE CENTER, A NURSING	CALIFORNIA	COVENANT CARE C	CARLINVILLE	BUILDING COMPA	3
4			CARSON NURSING & REHAB CENTER	NEVADA				4
5			CATERED MANOR	CALIFORNIA				5
6			CLINTON HOUSE HEALTH & REHABILITA	INDIANA				6
7			COURTYARD HEALTHCARE CENTER	CALIFORNIA				7
8			COVENANT CARE HILLTOP, LLC D/B/A HI	CHARLESTON				8
9			COVENANT CARE JACKSONVILLE, LLC D/	JACKSONVILLE				9
10			COVENANT CARE MEADOW MANOR, LLC	TAYLORVILLE				10
11			COVENANT CARE MIDWEST, INC. D/B/A C	LEBANON				11
12			COVENANT CARE SUNRISE, LLC D/B/A SU	VIRDEN				12
13			COVINGTON MANOR	INDIANA				13
14			DOWNEY CARE	CALIFORNIA				14
15			EAGLE POINT NURSING & REHAB CENTE	IOWA				15
16			EDGEWOOD MANOR NURSING CENTER	OHIO				16
17			EMERALD GARDENS NURSING CENTER	CALIFORNIA				17
18			ENCINITAS NURSING AND REHABILITATI	CALIFORNIA				18
19			ENNOBLE SKILLED NURSING & REHAB CE	IOWA				19
20			FAIRVIEW MANOR NURSING CENTER	OHIO				20
21			FRIENDSHIP HOME	CARLINVILLE, IL				21
22			GILROY HEALTHCARE & REHABILITATIC	CALIFORNIA				22
23			GRANT CUESTA NURSING & REHABILITA	CALIFORNIA				23
24			HIGHLAND HEALTH CARE CENTER	ILLINOIS				24
25			HUNTINGTON PARK NURSING CENTER	CALIFORNIA				25
26			LA JOLLA NURSING AND REHABILITATIO	CALIFORNIA				26
27			LAKELAND NURSING CENTER	INDIANA				27
28			LOS ALTOS SUB-ACUTE & REHABILITATI	CALIFORNIA				28
29			MISSION SKILLED NURSING & SUBACUTE	CALIFORNIA				29
30			NEBRASKA SKILLED NURSING CENTER	NEBRASKA				30

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			NORWOOD NURSING CENTER	INDIANA				1
2			PACIFIC COAST MANOR	CALIFORNIA				2
3			PACIFIC GARDENS NURSING & REHABILI	CALIFORNIA				3
4			PACIFIC HILLS MANOR	CALIFORNIA				4
5			PALO ALTO NURSING CENTER	CALIFORNIA				5
6			ROYAL CARE SKILLED NURSING CENTER	CALIFORNIA				6
7			SHORELINE CARE CENTER	CALIFORNIA				7
8			SILVER HILLS HEALTH CARE CENTER	NEVADA				8
9			SILVER RIDGE HEALTHCARE CENTER	NEVADA				9
10			ST. EDNA SUBACUTE & REHABILITATION	CALIFORNIA				10
11			THE RESIDENCE AT MCCORMICK'S CREE	INDIANA				11
12			TURLOCK NURSING AND REHABILITATIO	CALIFORNIA				12
13			TURLOCK RESIDENTIAL	CALIFORNIA				13
14			UNIVERSITY PARK NURSING CENTER	INDIANA				14
15			VALLE VISTA CONVALESCENT CENTER	CALIFORNIA				15
16			VERSAILLES HEALTH CARE CENTER	OHIO				16
17			VILLA GEORGETOWN	OHIO				17
18			VILLA SPRINGFIELD	OHIO				18
19			VINTAGE FAIRE NURSING & REHABILITA	CALIFORNIA				19
20			VINTAGE FAIRE RESIDENTIAL	CALIFORNIA				20
21			WAGNER HEIGHTS NURSING & REHABILI	CALIFORNIA				21
22			WAGNER HEIGHTS RESIDENTIAL	CALIFORNIA				22
23			WALDRON HEALTH AND REHAB CENTER	INDIANA				23
24			WILLOW TREE NURSING & REHABILITAT	CALIFORNIA				24
25			WRIGHT NURSING & REHAB CENTER (VII	OHIO				25
26			MARION REHAB AND ASSISTED LIVING C	INDIANA				26
27			PYRAMID POINT POST ACUTE REHABILIT	INDIANA				27
28								28
29								29
30								30

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Affirma Rehabilitation
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (888)468-4372
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	39	Physical Therapy	Direct Allocation			$	$		$ 74,118	1
2	39	Occupational Therapy	Direct Allocation						137,125	2
3	39	Speech Therapy	Direct Allocation						27,861	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					$	$		$ 239,104	25

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Covenant Care California, LLC
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949)349-1200
Fax Number: (949)349-1900

	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	17	Indirect Care	Accumulated Cost			$	$		$ 110,161	1
2	15	Direct Care	Accumulated Cost						10,313	2
3	32	Capital - Interest	Accumulated Cost						65,525	3
4	30	Capital - Depreciation	Accumulated Cost						10,398	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					$	$		$ 196,397	25

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Covenant Care	X									62,525	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 62,525	9
	B. Non-Facility Related*											
10	Interest Income		X								(7)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7)	14
15	TOTALS (line 9+line14)						$	$			$ 62,518	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** 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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 18,853	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,853	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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		$ 18,853	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	17,229	8
	2013	17,412	9
	2014	17,724	10
	2015	17,882	11
	2016	18,853	12

Facility does not accrue real estate taxes

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Skilled Nsg & Rehab COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0042846

CONTACT PERSON REGARDING THIS REPORT Carol Sparks

TELEPHONE (949) 349-1222 FAX #: (949) 349-1122

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-001-068-00	Long Term Care Property	$ 18,853.20	$ 18,853.20
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,853.20	$ 18,853.20

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,488 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1997	$ 30,000	1
2					2
3	TOTALS			$ 30,000	3

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	49		1997	1974	$ 528,512	$		$	$	$	4
5	49		2014	1974	978,254	63,333			(63,333)	601,667	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	1,075		20				9
10	Various			1998	130,263		20				10
11	Various			1999	23,555		20				11
12	Various			2000	3,911		20				12
13	Various			2001	27,563		20				13
14	Various			2002	99,247		20				14
15	Various			2003	8,078		20				15
16	Various			2004	4,154		20				16
17	Various			2005	9,288		20				17
18	Various			2006	52,141		20				18
19	Various			2007	38,143		20				19
20	Various			2008	14,692		20				20
21	Various			2009	7,900		20				21
22	Various			2011	11,215		20				22
23	Various			2013	13,313		20				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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)					10,398	10,398		68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 1,951,304	$ 63,333		$ 10,398	$ (52,935)	$ 601,667	70

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,951,304	$ 63,333		$ 10,398	$ (52,935)	$ 601,667	1
2	Trane 5 Ton Air Handler	2014	5,910		20	844	844	2,603	2
3	Plumbing for Eye Wash Stations	2014	5,941		20	849	849	2,546	3
4	Mag Locks	2017	1,523		7	181	181	181	4
5	Amano Thru-Wall A/C Unit	2017	552		7	26	26	26	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,965,230	$ 63,333		$ 12,298	$ (51,035)	$ 607,023	34

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 25,159	$	$ 73,587	$ 73,587	10	$ 38,539	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	255,433				10	255,433	73
74								74
75	TOTALS	$ 280,592	$	$ 73,587	$ 73,587		$ 293,972	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,275,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,333	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,885	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,552	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 900,995	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Friendship Real Estate
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:		49		$ 139,190			3
4	Additions							4
5								5
6	Parking Lot Rent				1,650			6
7	TOTAL		49		$ 140,840 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 26,896 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	Facility		$ #######	$	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.

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Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate
CCMIDWST	031	6110	60000620	Acc 10/17 ISV Joerns-0095127845-01	169.57	10	2017	JRNL00189880	10/31/17
CCMIDWST	031	6110	60000620	Acc 10/17 ISV Joerns-0095127845-01	-169.57	11	2017	JRNL00190508	11/30/17
CCMIDWST	031	6110	60000620	Acc 11/17 ISV Joerns-0095159959-01	76.4	11	2017	JRNL00190618	11/30/17
CCMIDWST	031	6110	60000620	Acc 11/17 ISV Joerns-0095159959-01	-76.4	12	2017	JRNL00191309	12/31/17
CCMIDWST	031	6110	60000620	Acc 11/17 ISV Joerns-0095159987-01	164.1	11	2017	JRNL00190618	11/30/17
CCMIDWST	031	6110	60000620	Acc 11/17 ISV Joerns-0095159987-01	-164.1	12	2017	JRNL00191309	12/31/17
CCMIDWST	031	6110	60000620	Acc 12/17 ISV Joerns-0095194492-01	169.57	12	2017	JRNL00191486	12/31/17
CCMIDWST	031	6110	60000620	Acc ISV-Joerns 9/17 Inv95092676	360	9	2017	JRNL00188959	09/30/17
CCMIDWST	031	6110	60000620	Acc ISV-Joerns 9/17 Inv95092676	-360	10	2017	JRNL00189609	10/31/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	31	1	2017	JRNL00181780	01/25/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	185	1	2017	JRNL00182248	01/31/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	8.44	2	2017	JRNL00182663	02/24/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	8.44	2	2017	JRNL00182738	02/28/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	185	2	2017	JRNL00182738	02/28/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	8.44	2	2017	JRNL00182797	02/28/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	185	2	2017	JRNL00182797	02/28/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	185	3	2017	JRNL00184152	03/31/17
CCMIDWST	031	6110	60000620	AMERICAN MEDICAL SUPPLY - 031	8.44	3	2017	JRNL00184152	03/31/17
CCMIDWST	031	6110	60000620	Bk Apr expense Joerns	238.41	4	2017	JRNL00185112	04/30/17
CCMIDWST	031	6110	60000620	Bk Apr expense Joerns	238.41	4	2017	JRNL00185112	04/30/17
CCMIDWST	031	6110	60000620	Bk Apr expense Joerns	-238.41	5	2017	JRNL00185206	05/31/17
CCMIDWST	031	6110	60000620	Bk Apr expense Joerns	-238.41	5	2017	JRNL00185206	05/31/17
CCMIDWST	031	6110	60000620	CR-SMS Q1/17 rebate	-27.38	6	2017	JRNL00186681	06/30/17
CCMIDWST	031	6110	60000620	CR-SMS Q2/17 rebate	-37.97	7	2017	JRNL00187476	07/31/17
CCMIDWST	031	6110	60000620	CR-SMS Q3/17 rebate	-16.92	12	2017	JRNL00191675	12/31/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	360	10	2017	JRNL00189719	10/09/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	-45.71	10	2017	JRNL00189967	10/22/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	-202.43	10	2017	JRNL00189967	10/22/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	-195.9	10	2017	JRNL00189967	10/22/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	169.57	11	2017	JRNL00190361	11/06/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	164.1	12	2017	JRNL00191339	12/11/17
CCMIDWST	031	6110	60000620	ISAVE - JOERNS - 099	76.4	12	2017	JRNL00191339	12/11/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	402.69	1	2017	JRNL00181921	01/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	402.69	1	2017	JRNL00181921	01/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	402.69	1	2017	JRNL00181921	01/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	402.69	1	2017	JRNL00181921	01/31/17

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Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	177.64	5	2017	JRNL00185158	05/19/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	177.64	5	2017	JRNL00185158	05/19/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	162.38	5	2017	JRNL00185158	05/19/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	183.57	6	2017	JRNL00186070	06/20/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	183.57	6	2017	JRNL00186070	06/20/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	108.25	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	118.42	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	177.64	7	2017	JRNL00187004	07/26/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	114.87	7	2017	JRNL00187445	07/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	84	7	2017	JRNL00187587	07/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	217.46	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	349.15	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	349.15	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	349.15	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	349.15	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	167.79	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	14.03	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	275.53	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	19.68	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	19.68	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	275.53	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	151.55	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	JOERNS LLC - 031	372	12	2017	JRNL00192158	12/31/17
CCMIDWST	031	6110	60000620	Rcl Joerns Inv#90824749 fr 8131-0620	167.79	6	2017	JRNL00186737	06/30/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	206.53	1	2017	JRNL00181921	01/31/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	222.43	2	2017	JRNL00182671	02/24/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	282.71	3	2017	JRNL00183603	03/30/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	230.87	4	2017	JRNL00184425	04/28/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	191.54	5	2017	JRNL00185366	05/31/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	142.5	7	2017	JRNL00187445	07/31/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	158.06	7	2017	JRNL00187587	07/31/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	151.41	8	2017	JRNL00188161	08/31/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	151.41	9	2017	JRNL00188797	09/28/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	139.32	10	2017	JRNL00189724	10/30/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	131.48	11	2017	JRNL00190526	11/29/17
CCMIDWST	031	6110	60000620	SPECIALIZED MEDICAL SERVICES - 031	156.43	12	2017	JRNL00191474	12/31/17

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Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate
CCMIDWST	031	6200	60000620	ACE HARDWARE - 031	44	3	2017	JRNL00184152	03/31/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	1	2017	JRNL00180992	01/04/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	2	2017	JRNL00182626	02/23/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	3	2017	JRNL00183079	03/09/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	4	2017	JRNL00184161	04/13/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	5	2017	JRNL00184972	05/10/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	6	2017	JRNL00185743	06/09/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	7	2017	JRNL00186732	07/13/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	8	2017	JRNL00187454	08/08/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	9	2017	JRNL00188606	09/18/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	10	2017	JRNL00189422	10/16/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	12	2017	JRNL00191213	12/19/17
CCMIDWST	031	6500	60000620	AC CROWDER CORP - 031	100	12	2017	JRNL00191213	12/19/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	1	2017	JRNL00181245	01/10/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	2	2017	JRNL00182147	02/10/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	3	2017	JRNL00183079	03/09/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	4	2017	JRNL00184161	04/13/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	5	2017	JRNL00184972	05/10/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	6	2017	JRNL00185743	06/09/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	7	2017	JRNL00186732	07/13/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	8	2017	JRNL00187454	08/08/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	139.46	9	2017	JRNL00188606	09/18/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	142.6	10	2017	JRNL00189422	10/16/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	142.6	11	2017	JRNL00190375	11/16/17
CCMIDWST	031	6500	60000620	ECOLAB - 031	142.6	12	2017	JRNL00191220	12/19/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	12	2017	JRNL00190479	12/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	11	2017	JRNL00189915	11/04/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	10	2017	JRNL00189088	10/07/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	9	2017	JRNL00187911	09/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	8	2017	JRNL00187034	08/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	7	2017	JRNL00186053	07/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	6	2017	JRNL00185178	06/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	5	2017	JRNL00184442	05/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	4	2017	JRNL00183418	04/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	3	2017	JRNL00182571	03/01/17
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	1	2017	JRNL00181957	01/31/17

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Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate
CCMIDWST	031	6901	60000620	HEWLETT-PACKARD FINANCIAL SERVICES - 099	89.21	2	2017	JRNL00181891	02/01/17
CCMIDWST	031	8131	60000620	SPECIALIZED MEDICAL SERVICES - 031	100.94	8	2017	JRNL00188161	08/31/17
CCMIDWST	031	8131	60000620	SPECIALIZED MEDICAL SERVICES - 031	136.25	7	2017	JRNL00187587	07/31/17
CCMIDWST	031	8131	60000620	SPECIALIZED MEDICAL SERVICES - 031	364.62	7	2017	JRNL00187445	07/31/17
CCMIDWST	031	8131	60000620	Rcl Joerns Inv#90824749 to 6110-0620	-167.79	6	2017	JRNL00186737	06/30/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	3	12	2017	JRNL00192266	12/31/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	-3	12	2017	JRNL00192227	12/31/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	288	8	2017	JRNL00188161	08/31/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	132	7	2017	JRNL00187445	07/31/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	294	7	2017	JRNL00187445	07/31/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	116.91	7	2017	JRNL00187006	07/26/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	-12.99	7	2017	JRNL00187004	07/26/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	-63.62	7	2017	JRNL00187004	07/26/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	90.93	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	12.99	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	65.5	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	129.93	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	23.82	7	2017	JRNL00186976	07/25/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	167.79	6	2017	JRNL00186070	06/20/17
CCMIDWST	031	8131	60000620	JOERNS LLC - 031	318.26	5	2017	JRNL00185158	05/19/17
CCMIDWST	031	8131	60000620	CR-SMS Q4/16 rebate	-59.66	2	2017	JRNL00183404	02/28/17
CCMIDWST	031	8131	60000620	CR-SMS Q3/17 rebate	-16.87	12	2017	JRNL00191675	12/31/17
CCMIDWST	031	8131	60000620	CR-KCl rebate Q3&4/16	-133.64	6	2017	JRNL00186675	06/30/17
CCMIDWST	031	8131	60000620	CR- Joerns Q3-17 Rebate	-33.21	11	2017	JRNL00190941	11/30/17
CCMIDWST	031	8131	60000620	CR- Joerns 3Q15-1Q17 Rebate	-327.53	12	2017	JRNL00192881	12/31/17
CCMIDWST	031	8131	60000620	CR- Joerns 2Q17 Rebate	-52.26	12	2017	JRNL00192881	12/31/17
CCMIDWST	031	8131	60000620	Bk Apr expense Joerns	-167.79	5	2017	JRNL00185206	05/31/17
CCMIDWST	031	8131	60000620	Bk Apr expense Joerns	167.79	4	2017	JRNL00185112	04/30/17
CCMIDWST	031	8131	60000620	AMERICAN MEDICAL SUPPLY - 031	31	2	2017	JRNL00182663	02/24/17
CCMIDWST	031	8131	60000620	AMERICAN MEDICAL SUPPLY - 031	150	1	2017	JRNL00181780	01/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	12	2017	JRNL00191268	12/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	11	2017	JRNL00190453	11/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	10	2017	JRNL00189593	10/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	9	2017	JRNL00188785	09/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	8	2017	JRNL00187891	08/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	7	2017	JRNL00186974	07/25/17

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Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	6	2017	JRNL00186150	06/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	5	2017	JRNL00185325	05/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	4	2017	JRNL00184360	04/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	3	2017	JRNL00183529	03/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	982	2	2017	JRNL00182681	02/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	1156.8	1	2017	JRNL00181821	01/25/17
CCMIDWST	031	8200	60000620	ACCELERATED CARE PLUS - 099	-174.8	1	2017	JRNL00181820	01/27/17
TOTAL	031	8200	60000620		**26,895.99**				

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	0.00 hrs	$ 0	2,647	$ 131,928	$ 0	2,647	$ 131,928	1
2	Licensed Speech and Language Development Therapist	V10A	0.00 hrs	0	736	26,805	0	736	26,805	2
3	Licensed Recreational Therapist	V10A	0.00 hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00 hrs	0	1,885	71,309	0	1,885	71,309	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	##### hrs	5,452	0	0	926	403	6,378	8
9	Pharmacy	V39	0.00 # of prescrpts	0	0	0	37,547		37,547	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00	0	0	0	6,928		6,928	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00	0	0	0	4,308		4,308	13
14	TOTAL			$ 5,452	5,268	$ 230,042	$ 49,709	5,671	$ 285,203	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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 (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	$ 2,600	$ 2,600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 84,876)	328,790	328,790	3
4	Supply Inventory (priced at)	20,855	20,855	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,167	1,167	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Inventories	3,583	3,583	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 356,995	$ 356,995	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		30,000	13
14	Buildings, at Historical Cost	40,377	1,940,377	14
15	Leasehold Improvements, at Historical Cos	24,854	24,854	15
16	Equipment, at Historical Cost	280,592	280,592	16
17	Accumulated Depreciation (book methods)	(299,328)	(900,995)	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): Medicare Cost Settlements	15,726	15,726	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,221	$ 1,390,554	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 419,216	$ 1,747,549	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30	$ 30	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,632	36,632	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Intercompany Liability	(2,391,050)	(1,340,566)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (2,354,388)	$ (1,303,904)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	QAF & Deferred Rent	(189,385)	(189,385)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (189,385)	$ (189,385)	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,543,773)	$ (1,493,289)	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,962,989	$ 3,240,838	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 419,216	$ 1,747,549	48

***(See instructions.)**

131-Friendship Real Estate

For the Twelve Months Ending December 31, 2017

Acct Number	Dept	Account	Description	***YTD***	**Acct #**
131-0000-12010000	0000	12010000	LAND	30,000.00	
131-0000-12210000	0000	12210000	BLDG & IMPV - FACILITY BUILDINGS	1,900,000.00	
131-0000-12710000	0000	12710000	ACC DEPR - FACILITY BUILDINGS	(601,666.90)	
131-0000-20800099	0000	20800099	INTERCOMPANY	###########	
131-0000-24400100	0000	24400100	EQUITY - RETAINED EARNINGS	(277,848.88)	
131-0000-29990000	0000	29990000	CURRENT YEAR PROFIT/LOSS	75,856.68	
131-7100-70009220	7100	70009220	PROPERTY DEPR-BLDGS & IMPROVEMENTS	63,333.36	
131-8000-40003430	8000	40003430	MISC. REV. RENT INCOME	(139,190.04)	
				-	

(????10000000 TO...	Total Assets	1,328,333.10
(????20900000 TO...	Total Liabilities - Continued	(201,992.20)
(????3??????? TO...	Total Profit/Loss	(75,856.68)

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,042,837	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,042,836	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(79,847)	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (79,847)	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)**	$ 2,962,989	24 *

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 1,674,124	1
2	Discounts and Allowances for all Levels	(212,448)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,461,676	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	732,038	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 732,038	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	38,291	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,671	19
20	Radiology and X-Ray	2,257	20
21	Other Medical Services	6,773	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,992	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL		28
28a	Misc Revenue		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,245,713	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	294,586	31
32	Health Care	1,001,587	32
33	General Administration	681,805	33
	B. Capital Expense		
34	Ownership	203,874	34
	C. Ancillary Expense		
35	Special Cost Centers	55,329	35
36	Provider Participation Fee	88,379	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,325,560	40
41	**Income before Income Taxes (line 30 minus line 40)****	(79,847)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (79,847)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 785,812	44
45	Private Pay - Net Inpatient Revenue	654,896	45
46	Medicare - Net Inpatient Revenue	619,107	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	54,248	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(652,387)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,461,676	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,965	1,965	$ 85,040	$ 43.28	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	3,757	4,179	141,238	33.80	3
4	Licensed Practical Nurses	6,123	6,123	127,315	20.79	4
5	CNAs & Orderlies	23,887	23,887	265,341	11.11	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	403	403	5,452	13.53	8
9	Activity Director	1,592	1,592	20,523	12.89	9
10	Activity Assistants	342	379	5,327	14.06	10
11	Social Service Workers	1,027	1,027	19,683	19.17	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,846	1,846	22,138	11.99	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	5,360	5,405	54,845	10.15	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,067	1,078	17,181	15.94	17
18	Housekeepers	2,958	2,958	29,963	10.13	18
19	Laundry	2,049	2,263	20,265	8.95	19
20	Administrator	1,587	1,587	48,981	30.86	20
21	Assistant Administrator	203	203	6,349	31.28	21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	2,169	2,215	47,164	21.29	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	647	651	14,799	22.73	31
32	Other Health Care(specify)	1,673	1,673	38,154	22.81	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	58,655	59,434	$ 969,758 *	$ 16.32	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	114	$ 6,056	01-03	35
36	Medical Director	30	5,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,031	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	8	547	11-03	44
45	Social Service Consultant	8	547	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	159	$ 15,681		49

C. CONTRACT NURSES

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

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bliss White	Administrator	0	$ 2,500
Miranda Witt	Administrator	0	10,000
Michael Olson	Administrator	0	39,038
Barbara Lowry	Administrator	0	3,792
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,330

B. Administrative - Other

Description	Amount
Management Fees - Covenant Care California, LLC	$ 112,254
TOTAL (agree to Schedule V, line 17, col. 3)	$ 112,254
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 184
ACCESS	Database Software	1,712
ABILITY NETWORK INC.	Data Processing	2,273
SHRED-IT	Document Destruction	783
WESCOM SOLUTIONS INC	Data Processing	2,970
NATIONAL DATACARE CORP	Data Processing	1,354
PINNACLE QUALITY INSIGHT	Customer Satisfaction	989
SMARTLINX SOLUTIONS, LLC	Labor Management Software	7,178
VERIFY	Performance Management	777
POINTCLICKCARE	Data Processing	9,594
CLINICAL RESOURCES	Healthcare Staffing	9,926
HEALTHLINK	Data Processing	157
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 37,897

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,038
Unemployment Compensation Insurance	
FICA Taxes	91,561
Employee Health Insurance	64,607
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	(16)
Vision Insurance	16
Employee Physicals	388
Life Insurance	1,991
Other Employee Benefits	3,676
TOTAL (agree to Schedule V, line 22, col.8)	$ 190,261

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,029
Health Care Worker Background Check	
(Indicate # of checks performed)	
License and Permits	2,711
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,730

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	832
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 832

* Attach copy of IMRF notifications

**See instructions.

Page 21 Supplemental - Legal Fees Detail

Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate	Purpose	(Non)Allowable
CCMIDWST	031	6901	60000470	Acr Sandberg Phoenix 10/16	-71.6	1	2017	JRNL00181411	01/31/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr Sandberg Phoenix 10/16	71.6	1	2017	JRNL00182427	01/31/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr Sandberg Phoenix 10/16	-71.6	2	2017	JRNL00182432	02/28/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr Sandberg Phoenix 10/16	71.6	2	2017	JRNL00183203	02/28/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	71.60	3	2017	JRNL00183365	03/16/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr Sandberg Phoenix 10/16	-71.6	3	2017	JRNL00183225	03/31/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr legal fees 7/17	184.05	7	2017	JRNL00187487	07/31/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr legal fees 7/17	-184.05	8	2017	JRNL00187575	08/31/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr legal fees 7/17	184.05	8	2017	JRNL00188369	08/31/17	Collections	NonAllowable
CCMIDWST	031	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	184.05	9	2017	JRNL00188656	09/19/17	collections	NonAllowable
CCMIDWST	031	6901	60000470	Acr legal fees 7/17	-184.05	9	2017	JRNL00188402	09/30/17	Collections	NonAllowable
TOTAL	031	6901	60000470		**184.05**						

Facility Name & ID Number Friendship Skilled Nsg & Rehab # 0042846 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. **AHCA,IHCA $3,234**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **7,697** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedure 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 fo 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 Departmen during this cost report period. $ **88,379**
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 classifiec 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 fo 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 benefit on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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 fo 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% Ln 1**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **Yes**
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 ou 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