FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Center

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 01/01/18 to 12/31/18 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, Director of Operations
(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 Center # 0050161 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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	14,000	10,726	5,592	30,318	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,000	10,726	5,592	30,318	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.22%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
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 11/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 2,902

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	273,192	14,110	5,904	293,206		293,206		293,206			1
2	Food Purchase		175,571		175,571		175,571	(307)	175,264			2
3	Housekeeping	219,448	17,948		237,396		237,396		237,396			3
4	Laundry	58,449	12,940		71,389		71,389		71,389			4
5	Heat and Other Utilities			180,615	180,615		180,615	(13,342)	167,273			5
6	Maintenance	74,784	62	51,801	126,647		126,647		126,647			6
7	Other (specify):* Infectious Waste			(4,626)	(4,626)		(4,626)		(4,626)			7
8	TOTAL General Services	625,873	220,631	233,694	1,080,198		1,080,198	(13,649)	1,066,549			8
	B. Health Care and Programs											
9	Medical Director			10,850	10,850		10,850		10,850			9
10	Nursing and Medical Records	1,646,838	57,638	41,648	1,746,124	15,469	1,761,593	3,521	1,765,114			10
10a	Therapy											10a
11	Activities	50,273	5,113	4,146	59,532		59,532	(1,683)	57,849			11
12	Social Services	62,343			62,343	(23,660)	38,683		38,683			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,759,454	62,751	56,644	1,878,849	(8,191)	1,870,658	1,838	1,872,496			16
	C. General Administration											
17	Administrative	92,067		120,000	212,067		212,067	(60,000)	152,067			17
18	Directors Fees											18
19	Professional Services			55,087	55,087	(15,584)	39,503		39,503			19
20	Dues, Fees, Subscriptions & Promotions			33,076	33,076	115	33,191	(14,707)	18,484			20
21	Clerical & General Office Expenses	98,960	14,235	51,475	164,670		164,670	(11,554)	153,116			21
22	Employee Benefits & Payroll Taxes			436,974	436,974		436,974	24,400	461,374			22
23	Inservice Training & Education			1,422	1,422		1,422		1,422			23
24	Travel and Seminar			1,293	1,293		1,293	(669)	624			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,394	67,394		67,394	(2,221)	65,173			26
27	Other (specify):* Disallowed Penalty					1,680	1,680	(1,680)				27
28	TOTAL General Administration	191,027	14,235	766,721	971,983	(13,789)	958,194	(66,431)	891,763			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,576,354	297,617	1,057,059	3,931,030	(21,980)	3,909,050	(78,242)	3,830,808			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 Center #0050161 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			177,415	177,415		177,415	23,897	201,312			30
31	Amortization of Pre-Op. & Org.			36,933	36,933		36,933	(36,933)				31
32	Interest			222,632	222,632		222,632	(102,687)	119,945			32
33	Real Estate Taxes			77,470	77,470	(1,680)	75,790	(10,265)	65,525			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			514,450	514,450	(1,680)	512,770	(125,988)	386,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,839	443,058	529,897		529,897		529,897			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			231,520	231,520		231,520		231,520			42
43	Other (specify):* Marketing					23,660	23,660	(23,660)				43
44	**TOTAL Special Cost Centers**		86,839	674,578	761,417	23,660	785,077	(23,660)	761,417			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,576,354	384,456	2,246,087	5,206,897		5,206,897	(227,890)	4,979,007			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 Center # 0050161 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ (1,479)	10	$	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	23,897	30		9
10	Interest and Other Investment Income	(21,918)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(307)	02		13
14	Non-Care Related Interest	(57,760)	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	(15,174)	21		18
19	Entertainment				19
20	Contributions	(65)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,829)	21		24
25	Fund Raising, Advertising and Promotional	(10,823)	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	(126,332)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (219,790)		$	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)	(8,100)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,100)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (227,890)		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 Center

ID# 0050161

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (9,051)	21	1
2	Flowers	(1,683)	11	2
3	Plant Cable	(13,342)	05	3
4	Amortization	(36,933)	31	4
5	Marketing Salary	(23,660)	43	5
6	Travel Seminar	(669)	24	6
7	Interest Expense (Closed Wing)	(23,009)	32	7
8	Disallowed Penalty Interest	(1,680)	27	8
9	Property Insurance (Closed Wing)	(2,221)	26	9
10	Real Estate Taxes (Closed Wing)	(10,265)	33	10
11	Professional Services (Land Sale)	(3,819)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(126,332)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(307)	0	0	0	0	0	0	0	0	0	0	(307)	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	(13,342)	0	0	0	0	0	0	0	0	0	0	(13,342)	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**	(13,649)	0	0	0	0	0	0	0	0	0	0	(13,649)	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	(1,479)	5,000	0	0	0	0	0	0	0	0	0	3,521	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,683)	0	0	0	0	0	0	0	0	0	0	(1,683)	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**	(3,162)	5,000	0	0	0	0	0	0	0	0	0	1,838	16
	C. General Administration													
17	Administrative	0	(60,000)	0	0	0	0	0	0	0	0	0	(60,000)	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	(14,707)	0	0	0	0	0	0	0	0	0	0	(14,707)	20
21	Clerical & General Office Expenses	(34,054)	22,500	0	0	0	0	0	0	0	0	0	(11,554)	21
22	Employee Benefits & Payroll Taxes	0	24,400	0	0	0	0	0	0	0	0	0	24,400	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(669)	0	0	0	0	0	0	0	0	0	0	(669)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,221)	0	0	0	0	0	0	0	0	0	0	(2,221)	26
27	Other (specify):*	(1,680)	0	0	0	0	0	0	0	0	0	0	(1,680)	27
28	**TOTAL General Administration**	(53,331)	(13,100)	0	0	0	0	0	0	0	0	0	(66,431)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,142)	(8,100)	0	0	0	0	0	0	0	0	0	(78,242)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor Health Center # 0050161 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	23,897	0	0	0	0	0	0	0	0	0	0	23,897	30
31	Amortization of Pre-Op. & Org.	(36,933)	0	0	0	0	0	0	0	0	0	0	(36,933)	31
32	Interest	(102,687)	0	0	0	0	0	0	0	0	0	0	(102,687)	32
33	Real Estate Taxes	(10,265)	0	0	0	0	0	0	0	0	0	0	(10,265)	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**	(125,988)	0	0	0	0	0	0	0	0	0	0	(125,988)	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):*	(23,660)	0	0	0	0	0	0	0	0	0	0	(23,660)	43
44	**TOTAL Special Cost Centers**	(23,660)	0	0	0	0	0	0	0	0	0	0	(23,660)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(219,790)	(8,100)	0	0	0	0	0	0	0	0	0	(227,890)	45

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. ☐ 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	$ 120,000	Legacy Health Systems	100.00%	$	$ (120,000)	1
2	V	17	Salaries		Legacy Health Systems		60,000	60,000	2
3	V	22	Taxes & Insurance		Legacy Health Systems		24,400	24,400	3
4	V	21	Telephone		Legacy Health Systems		10,000	10,000	4
5	V	21	Travel		Legacy Health Systems		11,000	11,000	5
6	V	21	Office Supplies		Legacy Health Systems		1,500	1,500	6
7	V	10	Nurse Consulting		Legacy Health Systems		5,000	5,000	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 120,000			$ 111,900	$ * (8,100)	14

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

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: ######

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 Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Planters Bank		X	Mortgage Payable	$27,706.16	11/1/08	$ 2,187,000	$ 3,364,899	10/30/22	4.5000	$ 139,471	1
2	Loan from Previous Owner		X	Mortgage Payable	$7,407.84	11/1/08	667,250		11/1/18	6.0000	2,392	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,114.00		$ 2,854,250	$ 3,364,899			$ 141,863	9
	B. Non-Facility Related*											
10	Interest Income		X								(11,644)	10
11	Interest Income	X									(10,273)	11
12	N/P D. Frances	X		Buyout 33% of Ownership	$6,134.02	1/1/16	1,250,000	1,138,519	9/1/2048	5.0000	57,760	12
13	Planters Bank		X	Closed Wing Allocation							23,009	13
14	TOTAL Non-Facility Related				$6,134.02		$ 1,250,000	$ 1,138,519			$ 58,852	14
15	TOTALS (line 9+line14)						$ 4,104,250	$ 4,503,418			$ 200,715	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 Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	76,510	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.)	$	75,790	2
3. Under or (over) accrual (line 2 minus line 1).	$	(720)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	76,510	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.	$	75,790	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	83,460	8
2014	83,236	9
2015	80,838	10
2016	75,330	11
2017	77,470	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor Health Center 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-12-23-251-007	Long Term Care Property	$ 1,040.08	$ 1,040.08
2.	10-12-23-251-008	Long Term Care Property	$ 72,485.72	$ 62,220.72
3.	10-12-23-254-001	Long Term Care Property	$ 549.06	$ 549.06
4.	10-12-23-254-002	Long Term Care Property	$ 549.06	$ 549.06
5.	10-12-23-256-003	Long Term Care Property	$ 132.16	$ 132.16
6.	10-12-23-276-005	Long Term Care Property	$ 248.88	$ 248.88
7.	10-12-23-279-005	Long Term Care Property	$ 784.90	$ 784.90
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,789.86	$ 65,524.86

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,960 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	120		2008	1964	$ 3,788,500	$	39	$ 97,141	$ 97,141	$ 987,600	4
5			2008	1964	(536,498)			(13,794)	(13,794)	(13,794)	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	248,035		20	12,265	12,265	122,648	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 Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 25,769	37
38	Sprinkler	2010	4,790		20	240	240	2,158	38
39	2 Water Heaters	2010	2,683		20	134	134	1,207	39
40	Holland Const/Aci Arch	2010	4,937		20			4,937	40
41	New Doors	2010	20,473		20	1,024	1,024	9,215	41
42	New Doors	2011	7,360		20	736	736	5,888	42
43	HVAC repairs	2011	4,414		20	441	441	3,529	43
44	Front Entrance Demolition, Millwork, Walls, Ceilings, Flooring	2011	34,675		20	1,734	1,734	13,871	44
45	New Roof	2011	5,899		20	590	590	4,720	45
46	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	2,552	46
47	Roof Repair	2011	3,100		20	155	155	1,240	47
48	Soffit & Fascia	2012	13,148		20	657	657	4,600	48
49	Two Bryant Rooftop A/Cs	2012	10,525		20	526	526	3,683	49
50	Sewer Line Replacement	2012	15,160		20	758	758	5,306	50
51	Kitchen Tile	2012	3,765		20	188	188	1,317	51
52	Soffit & Fascia	2012	4,183		20	209	209	1,463	52
53	Installation of 6" Seamless Guttering	2013	12,782		20	639	639	3,834	53
54	Installation of Walk in cooler	2013	8,460		20	423	423	2,538	54
55	Installation of Walk in Freezer	2013	9,130		20	457	457	2,742	55
56	Roof Replacement	2013	141,706		20	7,085	7,085	42,510	56
57	2 Carrier Ductless heat Pumps	2013	6,975		20	349	349	2,094	57
58	Concrete Resurfacing	2013	5,590		20	280	280	1,680	58
59	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	2,808	59
60	Dmt Gas Generator #54	2013	6,000		20	300	300	1,800	60
61	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	12,486	61
62	Rooftop AC unit	2014	5,355		10	536	536	2,462	62
63	Rebate of Installation of High Efficiency Lighting	2014	(18,266)		20	(913)	(913)	(4,565)	63
64	High Efficiency Lighting	2015	14,117		20	706	706	2,746	64
65	New Door for Snowman Freezer	2017	2,999		10	300	300	300	65
66	Fan on Boiler	2017	3,869		10	387	387	709	66
67	Actuator/Valve for Boiler	2018	8,929		7				67
68									68
69	Financial Statement Depreciation			175,625			(175,625)		69
70	TOTAL (lines 4 thru 69)		$ 3,957,420	$ 175,625		$ 119,284	$ (56,341)	$ 1,262,053	70

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

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 802,386	$	$ 80,238	$ 80,238	10	$ 794,243	71
72	Current Year Purchases	4,005	477	477		7	477	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 806,391	$ 477	$ 80,715	$ 80,238		$ 794,720	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	$ 4,924	76
77										77
78										78
79										79
80	TOTALS			$ 6,564	$ 1,313	$ 1,313	$		$ 4,924	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)	$ 4,981,875	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 177,415	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,312	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 23,897	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,061,697	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	Building Closed Wing/2008	$ 536,498	$ 13,794	$ 13,794	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 536,498	$ 13,794	$ 13,794	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ ____ Description: ____
(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 Center # 0050161 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$		$ 157,871	$		$ 157,871	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			91,457			91,457	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03/02	hrs			154,269	1,265		155,534	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				82,309		82,309	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				39,461	3,265		42,726	13
14	TOTAL			$		$ 443,058	$ 86,839		$ 529,897	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.

STATE OF ILLINOIS

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ (71,288)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,542,997		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,185		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	263,553		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,750,447	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	193,712		13
14	Buildings, at Historical Cost	3,905,238		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	863,642		16
17	Accumulated Depreciation (book methods)	(2,437,452)		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):	536,498		22
23	Other(specify):	175,405		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,237,043	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,987,490	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 790,795	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	290,634		29
30	Accrued Salaries Payable	120,695		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,510		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		73,827		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,352,461	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,138,519		39
40	Mortgage Payable	3,364,898		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Transfers	1,700,207		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,203,624	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,556,085	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,568,595)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,987,490	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,573,886)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,573,886)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,291	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	(24,000)	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)**	$ 5,291	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)**	$ (1,568,595)	24 *

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

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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	$ 4,276,211	1
2	Discounts and Allowances for all Levels	(387,934)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,888,277	3
	B. Ancillary Revenue		
4	Day Care	1,479	4
5	Other Care for Outpatients		5
6	Therapy	1,086,258	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,087,737	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	105,441	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,337	19
20	Radiology and X-Ray	4,241	20
21	Other Medical Services	31,796	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 196,815	23
	D. Non-Operating Revenue		
24	Contributions	65	24
25	Interest and Other Investment Income***	21,918	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,983	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Gain on sale of fixed assets**	41,376	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41,376	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,236,188	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,080,198	31
32	Health Care	1,878,849	32
33	General Administration	971,983	33
	B. Capital Expense		
34	Ownership	514,450	34
	C. Ancillary Expense		
35	Special Cost Centers	761,417	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)***	$ 5,206,897	40
41	**Income before Income Taxes (line 30 minus line 40)****	29,291	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 29,291	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,959,539	44
45	Private Pay - Net Inpatient Revenue	1,490,892	45
46	Medicare - Net Inpatient Revenue	275,623	46
47	Other-(specify) **Private Insurance**	78,588	47
48	Other-(specify) **Hospice**	83,635	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,888,277	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.**

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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	1,693	2,096	$ 83,853	$ 40.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,805	12,807	321,288	25.09	3
4	Licensed Practical Nurses	18,233	19,702	416,459	21.14	4
5	CNAs & Orderlies	58,760	61,174	792,848	12.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,410	4,709	50,273	10.68	10
11	Social Service Workers	1,232	1,628	38,683	23.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,955	21,215	273,192	12.88	15
16	Dishwashers					16
17	Maintenance Workers	3,123	3,255	74,784	22.98	17
18	Housekeepers	14,342	15,788	219,448	13.90	18
19	Laundry	5,072	5,565	58,449	10.50	19
20	Administrator	1,912	2,112	92,067	43.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,693	4,197	98,960	23.58	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	1,834	2,102	32,390	15.41	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	995	995	23,660	23.78	33
34	TOTAL (lines 1 - 33)	146,059	157,345	$ 2,576,354 *	$ 16.37	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	135	$ 6,574	01-03	35
36	Medical Director	192	10,850	09-03	36
37	Medical Records Consultant	16	1,000	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	62	5,425	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	56	4,027	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	461	$ 27,876		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	1,275	28,928	10-03	52
53	TOTAL (lines 50 - 52)	1,275	$ 28,928		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Heather Stich	Administrator	0	$ 92,067
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,067

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
Safe Mode	Computer Services	$ 4,585
Siteground Hosting	Computer Services	24
VIMO	Computer Services	197
Microsoft	Computer Services	421
Casamba	Computer Services	(550)
Dimension Group	Computer Services	(104)
Calhoun & Company	Accounting Fees	1,225
Hargis & Associates	Accounting Fees	4,250
Accelerated Medical Billing	Consulting Fees	339
McMahon Berger	Legal Fees	336
Filing Fees	Legal Fees	115
See Attached		44,249
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 55,087

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,464
Unemployment Compensation Insurance	
FICA Taxes	221,958
Employee Health Insurance	98,273
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	7,679
TOTAL (agree to Schedule V, line 22, col.8)	$ 461,374

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	$
Advertising: Employee Recruitment	10,000
Health Care Worker Background Check	
(Indicate # of checks performed 98)	583
Patient Background Checks 110	880
Dues and Subscriptions	356
Taxes and Licenses	6,005
Professional Fees	600
Admin education Expense	125
Less Contribution Income	(65)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,484

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	624
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 624

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2018 Ending: #

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? **120**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,751** 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. $ **231,520**
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 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