		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. **IDPH License ID Number:** 0023218

Facility Name: Friendship Vill Schaumburg

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1977

Type of Ownership:

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

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2019 to 03/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Jeff Nyberg
	(Title)	Controller
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Deborah Emerson Principal
	(Firm Name & Address)	CliftonLarsonAllen 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
	(Telephone)	(317) 574-9100 Fax # (317) 574-9707

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

In the event there are further questions about this report, please contact:
Name: Deborah Emerson Telephone Number: (312) 574-9100
Email Address:

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	250	Skilled (SNF)	199	72,834	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	250	TOTALS	199	72,834	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,440	32,242	15,218	60,900	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,440	32,242	15,218	60,900	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.61%

D. How many bed reserve days during this year were paid by the Department?
Non (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)
Home Health, Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/1977

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified ____ and days of care provided 13,604

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 03/30/20 Fiscal Year: 03/30/20

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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	2,568,469	277,690	1,474,364	4,320,523		4,320,523	(2,686,288)	1,634,235			1
2	Food Purchase		2,473,819		2,473,819		2,473,819	(1,540,442)	933,377			2
3	Housekeeping	1,279,545	119,506	25,575	1,424,626		1,424,626	(1,315,223)	109,403			3
4	Laundry	321,251	50,656	2,250	374,157		374,157	(32,697)	341,460			4
5	Heat and Other Utilities			1,786,865	1,786,865		1,786,865	(1,699,184)	87,681			5
6	Maintenance	1,834,221	134,963	1,726,262	3,695,446		3,695,446	(3,411,657)	283,789			6
7	Other (specify):* Medical Waste			1,414	1,414		1,414		1,414			7
8	TOTAL General Services	6,003,486	3,056,634	5,016,730	14,076,850		14,076,850	(10,685,491)	3,391,359			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	7,560,098	925,119	136,359	8,621,576	(132,973)	8,488,603		8,488,603			10
10a	Therapy	120,260		2,203,849	2,324,109		2,324,109	(555,327)	1,768,782			10a
11	Activities	674,910	6,544	41,878	723,332		723,332		723,332			11
12	Social Services	201,386			201,386		201,386		201,386			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	30,000			30,000		30,000		30,000			15
16	TOTAL Health Care and Programs	8,586,654	931,663	2,415,086	11,933,403	(132,973)	11,800,430	(555,327)	11,245,103			16
	C. General Administration											
17	Administrative			6,917,232	6,917,232	132,973	7,050,205	(5,806,755)	1,243,450			17
18	Directors Fees											18
19	Professional Services			14,440	14,440		14,440	(13,331)	1,109			19
20	Dues, Fees, Subscriptions & Promotions			109,240	109,240		109,240		109,240			20
21	Clerical & General Office Expenses		4,631	1,128,732	1,133,363		1,133,363	(1,105,173)	28,190			21
22	Employee Benefits & Payroll Taxes			5,912,576	5,912,576		5,912,576	(3,978,047)	1,934,529			22
23	Inservice Training & Education											23
24	Travel and Seminar			44,827	44,827		44,827		44,827			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,005,189	1,005,189		1,005,189	(927,996)	77,193			26
27	Other (specify):*											27
28	TOTAL General Administration		4,631	15,132,236	15,136,867	132,973	15,269,840	(11,831,302)	3,438,538			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	14,590,140	3,992,928	22,564,052	41,147,120		41,147,120	(23,072,120)	18,075,000			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 Vill Schaumburg #0023218 **Report Period Beginning:** 04/01/2019 **Ending:** 03/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,829,724	7,829,724		7,829,724	(7,156,764)	672,960			30
31	Amortization of Pre-Op. & Org.			191,837	191,837		191,837	(191,837)				31
32	Interest			6,055,139	6,055,139		6,055,139	(5,590,140)	464,999			32
33	Real Estate Taxes			537,230	537,230		537,230	(495,974)	41,256			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			101,553	101,553		101,553		101,553			35
36	Other (specify):*											36
37	TOTAL Ownership			14,715,483	14,715,483		14,715,483	(13,434,715)	1,280,768			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	113,106	813,695	273,878	1,200,679		1,200,679		1,200,679			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	70,320			70,320		70,320	(53,631)	16,689			41
42	Provider Participation Fee			444,196	444,196		444,196		444,196			42
43	Other (specify):*	4,504,615	47,281	2,661,105	7,213,001		7,213,001	(7,213,001)				43
44	TOTAL Special Cost Centers	4,688,041	860,976	3,379,179	8,928,196		8,928,196	(7,266,632)	1,661,564			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	19,278,181	4,853,904	40,658,714	64,790,799		64,790,799	(43,773,467)	21,017,332			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 Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	(555,327)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,345)	21		5
6	Rented Facility Space	(49,540)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(32,697)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(5,590,140)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(581,755)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(35,804,898)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,620,702)		$	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)	(1,152,765)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,152,765)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (43,773,467)		37

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

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

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

STATE OF ILLINOIS

Friendship Vill Schaumburg

ID# 0023218

Report Period Beginning: 04/01/2019

Ending: 03/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Revenue	$ (2,343)	2	1
2	Gift and Coffee Shop Incom	(53,631)	41	2
3	Assisted Living/Independent Living	(2,911,116)	43	3
4	Marketing Salaries	(1,019,498)	43	4
5	Marketing Expense	(2,269,999)	43	5
6	Home Health Salaries	(970,640)	43	6
7	Home Health Expenses	(41,748)	43	7
8	Amortization of Bond Costs	(191,837)	31	8
9	Miscellaneous Income	(150,214)	21	9
10	Dietary	(2,686,288)	1	10
11	Food Purchase	(1,538,099)	2	11
12	Housekeeping	(1,315,223)	3	12
13	Heat & Utilities	(1,649,644)	5	13
14	Maintenance	(3,411,657)	6	14
15	Administrative	(4,653,990)	17	15
16	Professional Services	(13,331)	19	16
17	Clerical & General	(366,859)	21	17
18	Employee Benefits	(3,978,047)	22	18
19	Insurance	(927,996)	26	19
20	Depreciation	(7,156,764)	30	20
21	Real Estate Taxes	(495,974)	33	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**	(35,804,898)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	(2,686,288)	0	0	0	0	0	0	0	0	0	0	(2,686,288)	1
2	Food Purchase	(1,540,442)	0	0	0	0	0	0	0	0	0	0	(1,540,442)	2
3	Housekeeping	(1,315,223)	0	0	0	0	0	0	0	0	0	0	(1,315,223)	3
4	Laundry	(32,697)	0	0	0	0	0	0	0	0	0	0	(32,697)	4
5	Heat and Other Utilities	(1,699,184)	0	0	0	0	0	0	0	0	0	0	(1,699,184)	5
6	Maintenance	(3,411,657)	0	0	0	0	0	0	0	0	0	0	(3,411,657)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,685,491)	0	0	0	0	0	0	0	0	0	0	(10,685,491)	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	(555,327)	0	0	0	0	0	0	0	0	0	0	(555,327)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(555,327)	0	0	0	0	0	0	0	0	0	0	(555,327)	16
	C. General Administration													
17	Administrative	(4,653,990)	(1,152,765)	0	0	0	0	0	0	0	0	0	(5,806,755)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,331)	0	0	0	0	0	0	0	0	0	0	(13,331)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,105,173)	0	0	0	0	0	0	0	0	0	0	(1,105,173)	21
22	Employee Benefits & Payroll Taxes	(3,978,047)	0	0	0	0	0	0	0	0	0	0	(3,978,047)	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	(927,996)	0	0	0	0	0	0	0	0	0	0	(927,996)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,678,537)	(1,152,765)	0	0	0	0	0	0	0	0	0	(11,831,302)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,919,355)	(1,152,765)	0	0	0	0	0	0	0	0	0	(23,072,120)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	(7,156,764)	0	0	0	0	0	0	0	0	0	0	(7,156,764)	30
31	Amortization of Pre-Op. & Org.	(191,837)	0	0	0	0	0	0	0	0	0	0	(191,837)	31
32	Interest	(5,590,140)	0	0	0	0	0	0	0	0	0	0	(5,590,140)	32
33	Real Estate Taxes	(495,974)	0	0	0	0	0	0	0	0	0	0	(495,974)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(13,434,715)	0	0	0	0	0	0	0	0	0	0	(13,434,715)	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	(53,631)	0	0	0	0	0	0	0	0	0	0	(53,631)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(7,213,001)	0	0	0	0	0	0	0	0	0	0	(7,213,001)	43
44	TOTAL Special Cost Centers	(7,266,632)	0	0	0	0	0	0	0	0	0	0	(7,266,632)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(42,620,702)	(1,152,765)	0	0	0	0	0	0	0	0	0	(43,773,467)	45

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 **Report Period Beginning:** 04/01/2019 **Ending:** 03/31/2020

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 PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 6,917,232	Friendship Village Executive/Corporate Allocation		$ 5,764,467	$ (1,152,765)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 6,917,232			$ 5,764,467	$ * (1,152,765)	14

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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	Mary Sheahen	BOD						1
2	Kathy Rivera	BOD						2
3	Loren Trimble	BOD						3
4	Duane Tyler	BOD						4
5	Cathie Tardy	BOD						5
6	Clark Delanois	BOD						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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mary Sheahen	Chair							$		1
2	Kathy Rivera	Secretary									2
3	Loren Trimble	Treasurer									3
4	Duane Tyler	Board Member									4
5	Cathie Tardy	Board Member									5
6	Clark Delanois	Board Member									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 Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 3/31/2020

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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Ratio	468,334	2	$ 4,320,523	$ 2,568,469	177,147	$ 1,634,235	1
2	2	Food Purchase	Meals Ratio	468,334	2	2,473,819	0	177,147	935,720	2
3	3	Housekeeping	Square Feet	737,530	2	1,424,626	1,279,545	56,638	109,403	3
4	4	Laundry	Pounds	1,067,194	2	374,157	321,251	994,380	348,628	4
5	5	Heat & Utilities	Square Feet	737,530	2	1,786,865	0	56,638	137,221	5
6	6	Maintenance	Square Feet	737,530	2	3,695,446	1,834,221	56,638	283,789	6
7	7	Other (disposal, waste)	Square Feet	737,530	2	1,414	0	56,638	109	7
8	17	Administrative	Employee Ratio	434	2	6,917,232	0	142	2,263,242	8
9	19	Professional Services	Square Feet	737,530	2	14,440	0	56,638	1,109	9
10	21	Clerical & General	Employee Ratio	434	2	545,263	0	142	178,404	10
11	22	Employee Benefits	Employee Ratio	434	2	5,912,576	0	142	1,934,529	11
12	26	Insurance	Square Feet	737,530	2	1,005,189	0	56,638	77,193	12
13	30	Depreciation	Actual	7,829,724	2	7,829,724	0	672,960	672,960	13
14	32	Interest	Square Feet	737,530	2	6,055,139	0	56,638	464,999	14
15	33	Real Estate Taxes	Square Feet	737,530	2	537,230	0	56,638	41,256	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 42,893,643	$ 6,003,486		$ 9,082,797	25

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Revenue Bond Series 2017		X	Bond Issuance			$ 122,550,000	$ 117,735,000		0.0501	$ 6,037,108	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Line of Credit							18,031	6
7												7
8												8
9	TOTAL Facility Related						$ 122,550,000	$ 117,735,000			$ 6,055,139	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule										(5,590,140)	13
14	TOTAL Non-Facility Related						$	$			$ (5,590,140)	14
15	TOTALS (line 9+line14)						$ 122,550,000	$ 117,735,000			$ 464,999	15

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

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

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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	627,660	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.)	$	530,241	2
3. Under or (over) accrual (line 2 minus line 1).	$	(97,419)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	634,649	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.	$	537,230	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	637,793	8
2016	671,047	9
2017	499,643	10
2018	502,705	11
2019	583,647	12

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Vill Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023218

CONTACT PERSON REGARDING THIS REPORT Jeff Nyberg

TELEPHONE (847) 843-4259 FAX #: (847) 884-5718

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	07-22-100-026-0000	Long Term Care Property	$ 565,006.96	$ 43,389.24
2.	07-22-101-042-0000	Long Term Care Property	$ 6,870.65	$ 527.63
3.	02-08-401-018	Long Term Care Property	$ 3,036.00	$ 233.15
4.	07-22-102-032-0000	Long Term Care Property	$ 8,732.95	$ 670.64
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 583,646.56	$ 44,820.65

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES ____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 737,530 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

Bridgegate Apartments - Independent Living Apartments - Buildings Separate From SNF
Bridgewater Place Apartment Homes - Independent Living Apartment Home - Buildings Separate From SNF
Crosswell Terrace Garden Homes - Independent Living Homes - Buildings Separate From SNF
The Willows Assisted Living - Buildings Separate From SNF
Reflections - Memory Support - Buildings SeperateFrom SNF
Clinic - 364,499 Square Feet of Space in Building Where SNF is Located
Home Care - 2,758 Square Feet in Bridgegate - Building Separate from SNF

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF	Approx. 50	1977	$ 132,065	1
2	Non-Allowable			4,392,192	2
3	TOTALS	#VALUE!		$ 4,524,257	3

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	178			1977	$ 1,760,825	$	40	$	$	$	4
5	10			1993	1,102,771	27,855	40	27,855			5
6	60			1998	2,934,069	73,352	40	73,352			6
7											7
8											8
	Improvement Type**										
9	1994 Fixed Assets			1994	174,574		Various				9
10	1995 Fixed Assets			1995	148,003		Various				10
11	1997 Fixed Assets			1997	470,386		Various				11
12	1998 Fixed Assets			1998	135,637		Various				12
13	1999 Fixed Assets			1999	134,210		Various				13
14	2000 Fixed Assets			2000	33,116		Various				14
15	2002 Fixed Assets			2002	27,260		Various				15
16	2003 Fixed Assets			2003	7,395		Various				16
17	2005 Fixed Assets			2005	131,485		Various				17
18	2006 Fixed Assets			2006	619,989		Various				18
19	2008 Fixed Assets			2008	279,410		Various				19
20	2010 Fixed Assets			2010	157,250		Various				20
21	2011 Fixed Assets			2011	15,871		Various				21
22	Bridgegate Garage Door Replacements			2012	4,650		15				22
23	Replace 4 External Doors in Health Center			2012	5,060		10				23
24	Renovations of Pavilion E & F			2013	2,004,128		20				24
25	IDPH Life Safety Survey Plan of Correction			2014	38,745		15				25
26	Gingko dining room remodel, including walls, doors, wall & door			2016	49,296		10				26
27	protection, window treatments and paint										27
28	Dining Room Improvements			2017	15,085		5				28
29	additional power& water lines; new door; new countertops;new cabinets										29
30	Elm & Forest Shower & Tub Room Remodel			2017	804,952		10				30
31	artchitect fees, lighting, doors, drywall, pipe insulations, roof leak patching										31
32	mirrors, glove box holders, shower heads, tubs, signs, locks with push button digintal access control										32
33	IDPH review fee, site remediation, concrete work, carpentry, flooring wall/tile, plumbing										33
34	Elm & Forest Pavilion Draintile - East Courtyards			2017	26,080		10				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 Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	Briarwood Elm Rehab Suites - architectural drawings; HVAC;	2020	$	$	10	$	$	$	37
38	directional signs; phones re-wired; carpeting; doors; mold								38
39	remediation; lights; flooring; bathrooms; security; fire protection;								39
40	shelving; locks; windows; beds; other								40
41									41
42									42
43									43
44	Financial Statement Depreciation			310,272		310,272		5,563,389	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,080,247	$ 411,479		$ 411,479	$	$ 5,563,389	70

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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	$ 1,845,704	$ 228,894	$ 228,894	$		$ 1,370,073	71
72	Current Year Purchases	936,974	32,587	32,587			32,587	72
73	Fully Depreciated Assets	2,126,984					2,126,984	73
74								74
75	TOTALS	$ 4,909,662	$ 261,481	$ 261,481	$		$ 3,529,644	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Van	2005	$ 20,852	$	$	$	5	$ 20,852	76
77		Pick-up Truck	2005	18,259				5	18,259	77
78										78
79										79
80	TOTALS			$ 39,111	$	$	$		$ 39,111	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)	$ 20,553,277	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 672,960	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 672,960	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,132,144	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Marketing/HR/Admin/Foundation Offi	$ 2,517,616	$ 65,369	$ 2,356,574	86
87	AL/IL/HH	84,365,306	3,622,004	67,406,070	87
88	Bridgewater	88,747,078	2,326,634	30,478,015	88
89	Friendship Center/MillCreek	5,850,356	147,215	1,837,658	89
90	Beauty Shop/Clinic/Commons/Dining/La	13,971,816	845,757	6,870,577	90
91	TOTALS	$ 195,452,172	$ 7,006,979	$ 108,948,894	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 Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 101,553 Description: Various Medical Equipment, Copier Lease
(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.

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	10a-3	hrs	$	7,930	$ 531,710	$	7,930	$ 531,710	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,650	184,138		2,650	184,138	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		12,489	832,877		12,489	832,877	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				813,695		813,695	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Laboratory	39-3					15,819		15,819	12
13	Other (specify): Radiology	39-3					41,305		41,305	13
14	TOTAL			$	23,069	$ 1,548,725	$ 870,819	23,069	$ 2,419,544	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 Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2020 (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	$ 8,729,809	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 926,056)	4,548,201		3
4	Supply Inventory (priced at cost)	186,027		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	91,217		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,555,254	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,636,031		12
13	Land	5,446,421		13
14	Buildings, at Historical Cost	119,280,491		14
15	Leasehold Improvements, at Historical Cost	71,817,547		15
16	Equipment, at Historical Cost	19,731,607		16
17	Accumulated Depreciation (book methods)	(118,134,265)		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): See Attached Schedule	17,835,630		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 129,613,462	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 143,168,716	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 11,290,660	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,293,304		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	634,649		32
33	Accrued Interest Payable	760,464		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	464,386		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 14,443,463	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	114,883,690		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	110,711,448		43
44	Investment Payable	2,560,417		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 228,155,555	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 242,599,018	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (99,430,302)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 143,168,716	$	48

*(See instructions.)

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (89,746,095)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (89,746,095)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(9,684,203)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(4)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (9,684,207)	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)**	$ (99,430,302)	24 *

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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	$ 22,361,732	1
2	Discounts and Allowances for all Levels	(2,044,065)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 20,317,667	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,178,453	6
7	Oxygen	49,416	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,227,869	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	55,974	12
13	Barber and Beauty Care	11,176	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	6,345	15
16	Rental of Facility Space	49,540	16
17	Sale of Drugs	17,141	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12	19
20	Radiology and X-Ray	250	20
21	Other Medical Services	25,085	21
22	Laundry	32,697	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 198,220	23
	D. Non-Operating Revenue		
24	Contributions	100,000	24
25	Interest and Other Investment Income***	417,814	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 517,814	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	IL/AL/HH Revenue	32,694,812	28
28a	Other Revenue	150,214	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,845,026	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 55,106,596	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	14,076,850	31
32	Health Care	11,933,403	32
33	General Administration	15,136,867	33
	B. Capital Expense		
34	Ownership	14,715,483	34
	C. Ancillary Expense		
35	Special Cost Centers	8,484,000	35
36	Provider Participation Fee	444,196	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 64,790,799	40
41	**Income before Income Taxes (line 30 minus line 40)****	(9,684,203)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (9,684,203)	43
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,185,223	44
45	Private Pay - Net Inpatient Revenue	1,314,555	45
46	Medicare - Net Inpatient Revenue	8,139,473	46
47	Other-(specify) Hospice/Life Care	8,678,416	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 20,317,667	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,032	$ 126,171	$ 62.09	1
2	Assistant Director of Nursing	4,003	4,003	197,355	49.30	2
3	Registered Nurses	84,840	84,840	3,142,402	37.04	3
4	Licensed Practical Nurses	8,993	8,993	272,401	30.29	4
5	CNAs & Orderlies	140,975	140,975	2,376,564	16.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,504	10,504	260,984	24.85	8
9	Activity Director	5,857	5,857	164,665	28.11	9
10	Activity Assistants	8,799	8,799	161,880	18.40	10
11	Social Service Workers	43,661	43,661	908,228	20.80	11
12	Dietician					12
13	Food Service Supervisor	9,920	9,920	187,725	18.92	13
14	Head Cook	4,056	4,056	83,723	20.64	14
15	Cook Helpers/Assistants	133,424	133,424	1,976,849	14.82	15
16	Dishwashers	22,212	22,212	293,199	13.20	16
17	Maintenance Workers	85,874	85,874	1,805,559	21.03	17
18	Housekeepers	46,223	46,223	689,689	14.92	18
19	Laundry	21,631	21,631	330,391	15.27	19
20	Administrator	2,080	2,080	132,973	63.93	20
21	Assistant Administrator	1,360	1,360	52,969	38.95	21
22	Other Administrative	28,727	28,727	1,041,685	36.26	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	12,387	12,387	224,590	18.13	31
32	Other Health Care(specify)	198,706	198,706	3,834,990	19.30	32
33	Other(specify)	26,160	26,160	1,013,188	38.73	33
34	TOTAL (lines 1 - 33)	902,423	902,423	$ 19,278,181 *	$ 21.36	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	33,000	9-3	36
37	Medical Records Consultant	67	3,600	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	16,050	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1,942	99,797	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dietary outside labor	monthly	488,094	1-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,009	$ 640,541		49

C. CONTRACT NURSES

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

Facility Name & ID Number Friendship Vill Schaumburg # 0023218 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Casey Pudwill	Administrator of HC		$ 132,973
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 132,973

B. Administrative - Other

Description	Amount
Management Fees FSO	$ 6,917,232
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 6,917,232

C. Professional Services

Vendor/Payee	Type	Amount
Atlas & Leviton	Legal	$ 14,440
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 14,440

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	1,374,906
Employee Health Insurance	282,123
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Vaccinations	10,613
Employee Programs	9,552
Transfer from Corporate	4,235,382
Less: Non-reimbursable benefits	(3,978,047)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,934,529

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	51,139
Health Care Worker Background Check (Indicate # of checks performed 349)	10,013
Patient Background Checks 740	13,433
Subscriptions and Publications	34,655
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 109,240

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,506
Seminar Expense	26,321
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 44,827

**See instructions.

GL 10-01-94-8430-00 FVS Legal Fees

Invoice Date	Firm Name	Allowable Amount	Non-Allowable Amount	Description of Service
03/31/2020	Atlas & Leviton	3,249.27		attorney's collection fees for HCC patients
08/31/2019	Atlas & Leviton	2,183.80	2,183.80	FV IL - Cash Receipts
05/30/2019	Atlas & Leviton	1,562.72		attorney's collection fees for HCC patients
06/06/2019	Atlas & Leviton	1,562.72		attorney's collection fees for HCC patients
11/30/2019	Atlas & Leviton	1,419.13		attorney's collection fees for HCC patients
01/31/2020	Atlas & Leviton	1,419.13		attorney's collection fees for HCC patients
09/30/2019	Atlas & Leviton	1,377.04		attorney's collection fees for HCC patients
10/31/2019	Atlas & Leviton	666.66	666.66	FV IL - Cash Receipts
09/30/2019	Atlas & Leviton	333.33	333.33	FV IL - Cash Receipts
11/30/2019	Atlas & Leviton	333.33	333.33	FV IL - Cash Receipts
12/31/2019	Atlas & Leviton	333.33	333.33	FV IL - Cash Receipts
TOTAL		**10,590.01**	**3,850.45**	

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. **CARF-$8,900 / IASN-$2,938 / LAIL-$48,744**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **135,233** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **444,196**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** 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 for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CLA - CliftonLarsonAllen LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.