

		FOR BHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0040717</u></p> <p><b>Facility Name:</b> <u>Friendship Care Center-Herrin</u></p> <p><b>Address:</b> <u>1900 North Park Avenue</u> <u>Herrin</u> <u>62948</u>          Number City Zip Code</p> <p><b>County:</b> <u>Williamson</u></p> <p><b>Telephone Number:</b> <u>618-942-2525</u> Fax # ( )</p> <p><b>HFS ID Number:</b> <u>36-3990444</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/95</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mendel S Schneider</u> <b>Telephone Number:</b> <u>847-933-1274</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td colspan="2">(Signed) <u>See Accountant's Report Attached</u></td> </tr> <tr> <td colspan="2">(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td colspan="2">(Firm Name &amp; Address) <u>Mendel S. Schneider &amp; Associates, CPA, PC</u> <u>4556 Oakton St., Ste 200, Skokie, IL 60076</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>847-933-1274</u></td> <td>Fax # <u>847-933-1283</u></td> </tr> <tr> <td colspan="3"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> </td> </tr> <tr> <td colspan="3" style="text-align: right;">Phone # (217) 782-1630</td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		<b>Paid Preparer</b>	(Signed) <u>See Accountant's Report Attached</u>		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Mendel S. Schneider &amp; Associates, CPA, PC</u> <u>4556 Oakton St., Ste 200, Skokie, IL 60076</u>			(Telephone) <u>847-933-1274</u>	Fax # <u>847-933-1283</u>	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>			Phone # (217) 782-1630		
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Facility Name & ID Number Friendship Care Center-Herrin

# 0040717 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 10/20/05

	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		Skilled (SNF)	8	576	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	41	17,309	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	150		152	302	8
9	SNF/PED					9
10	ICF	11,365	3,799		15,164	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,515	3,799	152	15,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.47%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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

YES  NO

I. On what date did you start providing long term care at this location?

Date started 02/01/95

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 02/01/95 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 8 and days of care provided 152

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

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

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

Facility Name & ID Number Friendship Care Center-Herrin # 0040717 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	71,465	5,177	3,528	80,170		80,170		80,170		1
2	Food Purchase		69,740		69,740	(3,500)	66,240		66,240		2
3	Housekeeping	43,067	7,691	3,574	54,332		54,332		54,332		3
4	Laundry	38,381	4,623		43,004		43,004		43,004		4
5	Heat and Other Utilities			29,985	29,985		29,985	614	30,599		5
6	Maintenance	16,390		18,708	35,098		35,098	919	36,017		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	169,303	87,231	55,795	312,329	(3,500)	308,829	1,533	310,362		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	355,688	28,746	1,421	385,855		385,855		385,855		10
10a	Therapy										10a
11	Activities	31,702			31,702		31,702		31,702		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	387,390	28,746	5,421	421,557		421,557		421,557		16
	<b>C. General Administration</b>										
17	Administrative	37,751			37,751		37,751	12,461	50,212		17
18	Directors Fees										18
19	Professional Services			62,323	62,323		62,323	(35,057)	27,266		19
20	Dues, Fees, Subscriptions & Promotions			3,364	3,364		3,364	(2,874)	490		20
21	Clerical & General Office Expenses	2,034	20,025	26,049	48,108		48,108	21,610	69,718		21
22	Employee Benefits & Payroll Taxes			96,819	96,819	3,500	100,319	8,365	108,684		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,263	1,263		1,263		1,263		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,342	39,342		39,342		39,342		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	39,785	20,025	229,160	288,970	3,500	292,470	4,505	296,975		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	596,478	136,002	290,376	1,022,856		1,022,856	6,038	1,028,894		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 Care Center-Herrin #0040717 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			1,183	1,183	1,183	23,572	24,755			30
31	Amortization of Pre-Op. & Org.						7,934	7,934			31
32	Interest			9,473	9,473	9,473	83,264	92,737			32
33	Real Estate Taxes			1,274	1,274	1,274	13,712	14,986			33
34	Rent-Facility & Grounds			168,000	168,000	168,000	(164,154)	3,846			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			179,930	179,930	179,930	(35,672)	144,258			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			26,828	26,828	26,828		26,828			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			26,828	26,828	26,828		26,828			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	596,478	136,002	497,134	1,229,614	1,229,614	(29,634)	1,199,980			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 Care Center-Herrin

# 0040717

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,315	30		9
10	Interest and Other Investment Income	(290)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(5,000)	21		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				24
25	Fund Raising, Advertising and Promotional	(2,874)	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 <u>ABS Management</u>	(38,345)	19		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (40,194)		\$	30

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	2	
		Amount	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)	(45,293)		34
35	Other- Attach Schedule <u>Allocate Indirect Cost</u>	55,853		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 10,560		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (29,634)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY					
48		49		50	
				51	
					52

Friendship Care Center-Herrin

ID# 0040717

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Friendship Care Center-Herrin

# 0040717

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	(2,874)	0	0	0	0	0	0	0	0	0	0	(2,874)	20
21	Clerical & General Office Expenses	(5,000)	250	0	0	0	0	0	0	0	0	0	(4,750)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(7,874)	250	0	0	0	0	0	0	0	0	0	(7,624)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(7,874)	250	0	0	0	0	0	0	0	0	0	(7,624)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Care Center-Herrin

# 0040717

Report Period Beginning:

01/01/05 Ending:

12/31/05

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	6,315	17,257	0	0	0	0	0	0	0	0	0	23,572	30
31	Amortization of Pre-Op. & Org.	0	7,934	0	0	0	0	0	0	0	0	0	7,934	31
32	Interest	(290)	83,554	0	0	0	0	0	0	0	0	0	83,264	32
33	Real Estate Taxes	0	13,712	0	0	0	0	0	0	0	0	0	13,712	33
34	Rent-Facility & Grounds	0	(168,000)	0	0	0	0	0	0	0	0	0	(168,000)	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	<b>TOTAL Ownership</b>	<b>6,025</b>	<b>(45,543)</b>	<b>0</b>	<b>(39,518)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,849)</b>	<b>(45,293)</b>	<b>0</b>	<b>(47,142)</b>	<b>45</b>								

Facility Name & ID Number Friendship Care Center-Herrin

# 0040717

Report Period Beginning:

01/01/05

Ending:

12/31/05

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		Herrin, LLC	Herrin	Bldg Rental
				ABS Management	Chicago	Management

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 168,000	The Willow of Herrin, LLC	100.00%	\$	\$ (168,000)	1
2	V	32 Interest		The Willow of Herrin, LLC		83,554	83,554	2
3	V	33 Real Estate Tax		The Willow of Herrin, LLC		14,986	13,712	3
4	V	21 Office		The Willow of Herrin, LLC		250	250	4
5	V	30 Depreciation		The Willow of Herrin, LLC		17,257	17,257	5
6	V	31 Amortization		The Willow of Herrin, LLC		7,934	7,934	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 168,000			\$ 123,981	\$ * (45,293)	14

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

Facility Name & ID Number Friendship Care Center-Herrin # 0040717 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Brandman		Administrative	5.00	1,852	1.6	3.10	ABS Salary	\$ 148	17-7	1
2	David Abell		Administrative	9.50	64,834	3.5	7.00	ABS Salary	5,166	17-7	2
3	Tamar Abell		Administrative	9.50	37,048	2.5	5.00	ABS Salary	2,952	17-7	3
4	Joseph Brandman		Administrative	19.00	52,653	3.5	7.00	ABS Salary	4,195	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,461		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 Care Center-Herrin

# 0040717

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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

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

Name of Related Organization ABS Management  
 Street Address 2711 W. Howard  
 City / State / Zip Code Chicago, IL 60645  
 Phone Number ( 773-338-4400  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Sam Brandman	664		\$ 2,000	\$ 2,000	49	\$ 148	1
2	17	David Abell	664		70,000	70,000	49	5,166	2
3	17	Tamar Abell	664		40,000	40,000	49	2,952	3
4	17	Joseph Brandman	664		56,848	56,848	49	4,195	4
5	21	Clerical	664		223,009	223,009	49	16,457	5
6	6	Repairs & Maintenance	664		12,451		49	919	6
7	34	Rent	664		52,116		49	3,846	7
8	22	Payroll Taxes	664		35,157		49	2,594	8
9	22	Health & Welfare	664		78,209		49	5,771	9
10	5	Utilities	664		8,318		49	614	10
11	19	Professional Fees	664		44,552		49	3,288	11
12	21	Office	664		134,198		49	9,903	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				\$ 756,858	\$ 391,857		\$ 55,853	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	American National Bank		X	Mortgage	\$11,364.06	08/11/98	\$ 1,400,000	\$ 1,122,718	08/11/08	7.6600	\$ 83,554	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MB Financial		X	Working Capital				150,000		7.2500	9,473	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$11,364.06		\$ 1,400,000	\$ 1,272,718			\$ 93,027	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(290)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(290)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,400,000	\$ 1,272,718			\$ 92,737	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 Care Center-Herrin

# 0040717 Report Period Beginning:

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12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 10,760 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

C. Does the Operating Entity?  (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?  (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).

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

1. Total Amount Incurred: 131,677 2. Number of Years Over Which it is Being Amortized: 15  
3. Current Period Amortization: 7,934 4. Dates Incurred: 02/01/95

Nature of Costs: Mortgage 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	<u>Facility</u>		<u>1995</u>	<u>\$ 40,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 40,000</b>	3

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**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1995		\$ 673,000	\$ 17,257	39	\$ 17,257	\$	\$ 187,661	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											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 Care Center-Herrin

# 0040717

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Ending:

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**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 673,000	\$ 17,257		\$ 17,257	\$	\$ 187,661	70

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

Facility Name & ID Number Friendship Care Center-Herrin # 0040717 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 257,213	\$ 1,183	\$ 7,498	\$ 6,315	10	\$ 257,213	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 257,213	\$ 1,183	\$ 7,498	\$ 6,315		\$ 257,213	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 970,213	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,440	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,755	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,315	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 444,874	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	Allocated from ABS Management				3,846			5
6					_____			6
7	TOTAL				\$ 3,846			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (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		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 Care Center-Herrin# 0040717Report Period Beginning: 01/01/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (62,118)	\$ (29,365)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	403,461	403,461	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,211	38,211	6
7	Other Prepaid Expenses	4,655	4,655	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 384,209	\$ 416,962	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		40,000	13
14	Buildings, at Historical Cost		673,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,760	257,213	16
17	Accumulated Depreciation (book methods)	(3,804)	(441,918)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	25,726	131,677	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,325)	(102,791)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,357	\$ 557,181	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 387,566	\$ 974,143	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 73,004	\$ 73,004	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	14,776	14,776	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,225	2,225	31
32	Accrued Real Estate Taxes(Sch.IX-B)		18,236	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to LLC</u>	331,652		36
37	<u>Due to Others</u>		114,931	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 571,657	\$ 373,172	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,122,718	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,122,718	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 571,657	\$ 1,495,890	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (184,091)	\$ (521,747)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 387,566	\$ 974,143	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (242,213)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (242,213)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	58,122	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 58,122	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (184,091)	24 *

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

Facility Name & ID Number Friendship Care Center-Herrin# 0040717Report Period Beginning: 01/01/05Ending: 12/31/05**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,287,785	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,287,785	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	290	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 290	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,288,075	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	312,329	31
32	Health Care	421,557	32
33	General Administration	288,970	33
<b>B. Capital Expense</b>			
34	Ownership	179,930	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	26,828	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,229,614	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	58,461	41
42	<b>Income Taxes</b>	(339)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 58,122	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Care Center-Herrin

# 0040717

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	2,178	2,218	\$ 39,214	\$ 17.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,596	2,684	42,168	15.71	3
4	Licensed Practical Nurses	6,331	6,808	77,728	11.42	4
5	CNAs & Orderlies	25,763	27,412	196,578	7.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,538	3,680	31,702	8.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,811	1,867	14,008	7.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,979	9,330	57,457	6.16	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,248	16,390	7.29	17
18	Housekeepers	5,697	6,193	43,067	6.95	18
19	Laundry	5,628	5,972	38,381	6.43	19
20	Administrator	2,640	2,640	37,751	14.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	240	240	2,034	8.48	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	67,433	71,292	\$ 596,478 *	\$ 8.37	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	84	\$ 3,528	1-3	35
36	Medical Director	72	4,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	1,421	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	184	\$ 8,949		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 Care Center-Herrin

# 0040717

Report Period Beginning: 01/01/05

Ending: 12/31/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Elizabeth Dunn	Administrator	0	\$ 37,751	Workers' Compensation Insurance	\$ 31,910	IDPH License Fee	\$		
				Unemployment Compensation Insurance	8,440	Advertising: Employee Recruitment			
				FICA Taxes	47,384	Health Care Worker Background Check			
				Employee Health Insurance	17,450	(Indicate # of checks performed)			
				Employee Meals	3,500	Advertising	2,874		
				Illinois Municipal Retirement Fund (IMRF)*		Subs-People	108		
						Subs-Com Readers	275		
						Various	107		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 37,751			Less: Public Relations Expense	( )		
(List each licensed administrator separately.)						Non-allowable advertising	(2,874)		
						Yellow page advertising	( )		
<b>B. Administrative - Other</b>						TOTAL (agree to Sch. V, line 20, col. 8)			
Description			Amount				\$ 490		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 108,684		
(Attach a copy of any management service agreement)									
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Mendel S Schneider	Accounting		\$ 8,300			\$	Out-of-State Travel	\$	
Architechniques, Ltd	Architect Fees		2,900						
Personnel Planners	UC Tax Consultant		1,255				In-State Travel		
ABS Management	Home Office-Adj Out		38,345						
Rebecca Whittington	Legal		9,273				Seminar Expense		
Meyer Magence	Legal		2,000				The Morand Group	610	
Sachnoff & Weaver	Legal		250				Various	653	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 62,323	TOTAL			\$	TOTAL	\$ 1,263
(If total legal fees exceed \$2500 attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.



**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? 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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,800 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. \_\_\_\_\_
- (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. \$ 26,828  
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. \$ 3,500 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.