

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024760

Facility Name: Friendship Manor

Address: 1209 21st Avenue Rock Island 61201
 Number City Zip Code

County: Rock Island

Telephone Number: (309) 786-9667 **Fax #** (309) 786-5611

HFS ID Number: _____

Date of Initial License for Current Owners: 06/29/79

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Ted Pappas **Telephone Number:** (309) 786-9667

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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) <u>Ted Pappas</u>	
	(Title) <u>CEO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Gwen A. Moser</u> <u>Partner</u>	
	(Firm Name & Address) <u>Eide Bailly, LLP</u> <u>3999 Pennsylvania Ave, Ste. 100</u>	
	(Telephone) <u>(563) 556-1790</u> Fax # <u>(563) 557-7842</u>	

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

Facility Name & ID Number Friendship Manor# 0024760 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>24,948</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>34</u>	Sheltered Care (SC)	<u>34</u>	<u>13,464</u>	5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>38,412</u>	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	<u>3,108</u>	<u>6,758</u>	<u>8,266</u>	<u>18,132</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>3,171</u>	<u>7,156</u>	<u>10,327</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,108</u>	<u>9,929</u>	<u>15,422</u>	<u>28,459</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.09%

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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 06/29/1979

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

YES Date _____ NO

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

YES NO If YES, enter number
of beds certified 63 and days of care provided 4,294Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Friendship Manor # 0024760 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	A. General Services											
1	Dietary	704,351	581,643	26,465	1,312,459		1,312,459	(879,192)	433,267			1
2	Food Purchase											2
3	Housekeeping	293,666	38,997	12,048	344,711		344,711		344,711			3
4	Laundry	52,901	40,362	8,920	102,183		102,183	(11,718)	90,465			4
5	Heat and Other Utilities			321,467	321,467		321,467		321,467			5
6	Maintenance	209,585	83,107	94,337	387,029		387,029	(800,330)	(413,301)			6
7	Other (specify):*											7
8	TOTAL General Services	1,260,503	744,109	463,237	2,467,849		2,467,849	(1,691,240)	776,609			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,806,735	211,718	50,691	2,069,144		2,069,144	(235,318)	1,833,826			10
10a	Therapy			368,042	368,042		368,042		368,042			10a
11	Activities	155,168	26,908	34,559	216,635		216,635	(149,559)	67,076			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,961,903	238,626	459,292	2,659,821		2,659,821	(384,877)	2,274,944			16
	C. General Administration											
17	Administrative	766,873	35,495	391,422	1,193,790		1,193,790	(697,068)	496,722			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			71,701	71,701		71,701		71,701			20
21	Clerical & General Office Expenses			202,577	202,577		202,577		202,577			21
22	Employee Benefits & Payroll Taxes			746,193	746,193		746,193	(53,613)	692,580			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,343	21,343		21,343	(1,258)	20,085			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			234,832	234,832		234,832		234,832			26
27	Other (specify):*											27
28	TOTAL General Administration	766,873	35,495	1,668,068	2,470,436		2,470,436	(751,939)	1,718,497			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,989,279	1,018,230	2,590,597	7,598,106		7,598,106	(2,828,056)	4,770,050			29

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

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

Facility Name & ID Number Friendship Manor #0024760 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	D. Ownership											
30	Depreciation			639,155	639,155		639,155	(333,988)	305,167			30
31	Amortization of Pre-Op. & Org.			20,692	20,692		20,692		20,692			31
32	Interest			363,284	363,284		363,284		363,284			32
33	Real Estate Taxes			168,697	168,697		168,697		168,697			33
34	Rent-Facility & Grounds			78,823	78,823		78,823		78,823			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,270,651	1,270,651		1,270,651	(333,988)	936,663			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			11,742	11,742		11,742		11,742			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			11,742	11,742		11,742		11,742			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,989,279	1,018,230	3,872,990	8,880,499		8,880,499	(3,162,044)	5,718,455			45

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

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	(39,055)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(190,166)	17		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,807)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,391)	17		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	(166,611)	17		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (416,030)		\$	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)			34
35	Other- Attach Schedule	(3,064,818)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,064,818)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,480,848)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Friendship Manor

ID# 0024760

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(39,055)	0	0	0	0	0	0	0	0	0	0	(39,055)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(39,055)	0	0	0	0	0	0	0	0	0	0	(39,055)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(376,975)	0	0	0	0	0	0	0	0	0	0	(376,975)	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL General Administration	(376,975)	0	0	0	0	0	0	0	0	0	0	(376,975)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(416,030)	0	0	0	0	0	0	0	0	0	0	(416,030)	29

STATE OF ILLINOIS

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(416,030)	0	(416,030)	45									

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
N/A						

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		\$			\$	\$	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		\$			\$	\$ *	14

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

Facility Name & ID Number Friendship Manor # 0024760 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Friendship Manor

0024760 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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	Series 2004 Revenue Bonds		x	Renovation	\$44,000.00	11/2004	\$ 6,345,000	\$ 6,029,268	11/2024	6.0000	\$ 363,284	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$44,000.00		\$ 6,345,000	\$ 6,029,268			\$ 363,284	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,345,000	\$ 6,029,268			\$ 363,284	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0024760

CONTACT PERSON REGARDING THIS REPORT Ted Pappas

TELEPHONE (309) 786-9667 FAX #: (309) 786-5611

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-345-07-00</u>	<u>Various</u>	\$ <u>935.32</u>	\$ _____
2. <u>10-325-18-90</u>	<u>Various</u>	\$ <u>161,139.08</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>162,074.40</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Friendship Manor

0024760 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 75,000 B. General Construction Type: Exterior Brick Frame Wood 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).

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: _____ 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	<u>Manor Property</u>	<u>10.79 acres</u>	<u>1973</u>	<u>\$ 252,793</u>	1
2					2
3	TOTALS	10.79 acres		\$ 252,793	3

Facility Name & ID Number Friendship Manor

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	63		1979	1979	\$ 1,861,259	\$ 33,526	40	\$ 33,526	\$	\$ 1,514,164	4
5	34		1985	1985	2,286,316	37,441	40	37,441		1,612,388	5
6											6
7											7
8											8
	Improvement Type**										
9	Cable Wire		1994		6,283	419	15	419		5,481	9
10	windows		1997		5,670	567	10	567		5,576	10
11	Remodel C Building		1997		63,096	3,155	20	3,155		30,759	11
12	Remodel A Building		1998		76,241	3,812	20	3,812		34,626	12
13	New door for boiler room		1998		5,346	214	25	214		1,834	13
14	Combine Apartment 1		1999		5,634	282	20	282		2,184	14
15	Combine Apartments		1999		14,581	729	20	729		5,650	15
16	Remodel Apartment		2000		54,683	2,734	20	2,734		19,823	16
17	Refurbished back loading deck		2000		14,175	1,418	10	1,418		10,041	17
18	Retread stairwells and walls repainted ILU		2001		12,346	1,235	10	1,235		7,716	18
19	Deck Repair East side of A, B, C and part of D Building		2001		46,584	3,106	15	3,106		18,634	19
20	Deck Repair 2002 (remaining buildings left)		2002		8,106	540	15	540		2,702	20
21	Carpet dining rooms, main reception entry, stairs		2002		14,852	2,970	5	2,970		14,110	21
22	Storage tank replaced in building A		2002		4,052	405	10	405		1,891	22
23	Door Back Loading Dock		2003		3,337	167	20	167		692	23
24	Sewer Relining		2003		14,300	572	25	572		2,574	24
25	Mainstreet Electrical Contract Work		2003		1,780	89	20	89		96	25
26	Mainstreet Patio Project/Gift Shop		2003		2,518	168	15	168		182	26
27	Mainstreet Engineering/Architectural Interiors		2003		5,090	339	15	339		368	27
28	Dirrectional Building Signs		2003		2,318	232	10	232		946	28
29	Combine Apartments A314&A316		2003		11,574	463	25	463		1,890	29
30	Deck Repair 2003 C Building		2003		2,026	135	15	135		551	30
31	Heat Exchangers in Health Center & Apartments		2003		4,936	329	15	329		1,344	31
32	Cap Construction Costs-Internal labor		2003		11,364	758	15	758		821	32
33	Signage Street Address		2003		754	151	5	151		591	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	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	Mainstreet Doors For Records Storage	2003	\$ 1,864	\$ 93	20	\$ 93	\$	\$ 101	37
38	Mainstreet Keystone Walls for Patio/Red maples	2003	11,604	580	20	580		629	38
39	Mainstreet Interior Modifications	2003	10,294	686	15	686		743	39
40	Mainstreet Bldg Permit/Plan Review	2003	3,040	203	15	203		220	40
41	Carpet-Elevator	2003	161	32	5	32		121	41
42	C212 Carpet	2003	675	135	5	135		495	42
43	Guest Room Furniture/Bed	2003	775	155	5	155		568	43
44	Signs-Directional	2003	4,200	840	5	840		3,010	44
45	AL Office Carpet	2003	484	97	5	97		347	45
46	Roof-D Bldg	2003	60,428	4,029	15	4,029		14,436	46
47	Mainstreet Auto Sprinkler System	2004	47,924	1,917	25	1,917		2,077	47
48	Mainstreet Ductwork, Diffusers, Air Intakes,Grille	2004	7,400	493	15	493		534	48
49	Mainstreet Wall Panel/Cornice	2004	3,884	777	5	777		842	49
50	Mainstreet Auto Sprinkler Flow/Tamper Switches	2004	2,270	151	15	151		164	50
51	Mainstreet Recessed Lighting	2004	897	60	15	60		65	51
52	Mainstreet Interiors	2004	1,493	100	15	100		108	52
53	Roof-A Bldg	2004	19,208	1,281	15	1,281		4,055	53
54	Mainstreet Plumbing/Piping	2004	26,144	1,307	20	1,307		1,416	54
55	Mainstreet New Windows/Patio Sliders	2004	13,001	867	15	867		939	55
56	Mainstreet Doors/Old Time Closet Doors	2004	5,173	345	15	345		374	56
57	Asphalt-C Bldg West	2004	1,935	645	3	645		1,878	57
58	Mainstreet Cap Const. Cost-Internal Labor	2004	60,000	4,000	15	4,000		4,333	58
59	Mainstreet Project Supplies	2004	2,585	172	15	172		187	59
60	Mainstreet Project Supplies/Equipment	2004	4,225	282	15	282		305	60
61	B & D Building Handrails	2004	5,140	1,028	5	1,028		2,998	61
62	Mainstreet Library Floor Covering	2004	4,121	824	5	824		893	62
63	Roof -A Bldg	2004	67,483	4,499	15	4,499		13,122	63
64	Mainstreet Doors Library/Exercise	2004	2,076	104	20	104		112	64
65	Mainstreet Fire Alarm System	2004	2,435	243	10	243		264	65
66	Bldg Repair Project-New Butterfly Valves	2004	2,365	118	20	118		128	66
67	Mainstreet Exercise/American Bank Doors	2004	3,892	259	15	259		281	67
68	Roof- C Bldg	2004	63,017	4,201	15	4,201		10,153	68
69	Mainstreet Windows/Fitness Room Mirrors	2005	1,111	74	15	74		80	69
70	TOTAL (lines 4 thru 69)		\$ 4,980,525	\$ 126,553		\$ 126,553	\$	\$ 3,363,612	70

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

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,980,525	\$ 126,553		\$ 126,553	\$	\$ 3,363,612	1
2	Water Tanks	2005	48,650	2,433	20	2,433		5,879	2
3	Office Construction Administration	2005	43,488	2,899	15	2,899		6,765	3
4	Cooling Tower Installation	2005	23,599	2,360	10	2,360		5,310	4
5	Board Room Construction	2005	11,606	774	15	774		1,741	5
6	Mainstreet Ducts, Diffusers, Grillers, Air Intakes	2005	1,649	110	15	110		119	6
7	Mainstreet Bank Floor Covering	2005	4,169	834	5	834		903	7
8	Fire Dampers Sheltered Care	2005	59,920	2,996	20	2,996		6,741	8
9	Mainstreet Project Doors/Supplies	2005	2,320	155	15	155		168	9
10	Boiler Upgrade	2005	77,938	3,897	20	3,897		8,443	10
11	Mainstreet Project Supplies	2005	1,600	107	15	107		116	11
12	Mainstreet Project Supplies	2005	731	49	15	49		53	12
13	Mainstreet Project Supplies	2005	10,371	691	15	691		749	13
14	Mainstreet-Cap Constr Costs Internal Labor	2005	30,116	2,008	15	2,008		2,175	14
15	Roof-BBldg Admin Bldg, Boiler/Garage	2005	159,605	10,640	15	10,640		23,396	15
16	Doors-Mainstreet Old Town Mall	2005	4,281	285	15	285		309	16
17	Architect Fees For Bed Conversion	2005	7,036	704	10	704		1,349	17
18	B-217/B-104 Cabinets/Countertops	2005	3,648	243	15	243		466	18
19	Roof Nursing/Activities Center	2005	97,595	9,760	10	9,760		18,706	19
20	Concrete Ramp A Bldg North Side	2005	7,560	504	15	504		924	20
21	Sprinkler System	2005	87,265	3,491	25	3,491		3,781	21
22	Storage Garage North Side Bldg A	2005	37,003	2,467	15	2,467		4,457	22
23	Remodel A Bldg-Fire Alarm/Nurse Call System	2005	77,815	7,782	10	7,782		13,893	23
24	Mainstreet Project-Supplies	2005	133,277	8,885	15	8,885		9,626	24
25	Fire Dampers Complete SC	2005	6,900	690	10	690		920	25
26	Storage Garage Platform Complete w/ 0146001438	2006	2,600	173	15	173		260	26
27	Mainstreet Project Supplies	2006	105,366	7,024	15	7,024		7,610	27
28	Mainstreet Project Supplies	2006	57,946	3,863	15	3,863		4,185	28
29	B122 New Patio Sliders	2006	1,552	103	15	103		138	29
30	C201 New Patio Sliders	2006	1,552	103	15	103		138	30
31	Mainstreet Project Supplies	2006	34,712	2,314	15	2,314		2,507	31
32	Mainstreet Project Supplies	2006	1,099	73	15	73		79	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,123,494	\$ 204,970		\$ 204,970	\$	\$ 3,495,518	34

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

Facility Name & ID Number Friendship Manor

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,123,494	\$ 204,970		\$ 204,970	\$	\$ 3,495,518	1
2	Call System/Fire Alarm	2006	20,105	2,010	10	2,010		2,178	2
3	Mainstreet Country Store Sliding Door	2006	2,423	162	15	162		175	3
4	Mainstreet Project Supplies	2006	21,214	1,414	15	1,414		1,532	4
5	Special Project Building	2006	14,845	990	15	990		1,072	5
6	Mainstreet Capital Const Costs Internal Labor	2006	69,334	4,622	15	4,622		5,007	6
7	Mainstreet Project	2006	26,406	1,760	15	1,760		1,760	7
8	Bridge For East Entrance B Bldg	2006	26,089	1,594	15	1,594		1,594	8
9	Shower Base, Kitchen Sink	2006	1,622	81	20	81		81	9
10	Cooling Tower Motor (Computer)	2006	1,725	345	5	345		345	10
11	C101 Patio Slider Door	2006	1,757	117	15	117		117	11
12	Stairs/Sidewalk Between A&B Bldg	2006	17,685	1,179	15	1,179		1,179	12
13	Nurse Call System Alarm/Detect tes	2006	8,944	820	10	820		820	13
14	Landscaping Culvers Lawn & Landscape	2006	4,345	362	10	362		362	14
15	Receptacles-GFI Weatherproof (13)	2006	2,630	175	10	175		175	15
16	Electrical Boxes For All Bldgs-out	2006	1,416	94	10	94		94	16
17	Bridge Bldg B East	2006	2,899	129	15	129		129	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,346,933	\$ 220,824		\$ 220,824	\$	\$ 3,512,138	34

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

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
1		\$ 6,346,933	\$ 220,824		\$ 220,824	\$	\$ 3,512,138	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,346,933	\$ 220,824		\$ 220,824	\$	\$ 3,512,138	34

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

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,346,933	\$ 220,824		\$ 220,824	\$	\$ 3,512,138	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,346,933	\$ 220,824		\$ 220,824	\$	\$ 3,512,138	34

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

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	\$ 1,606,706	\$ 79,628	\$ 79,628	\$		\$ 697,354	71
72	Current Year Purchases	12,738	2,548	2,548			2,548	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,619,444	\$ 82,176	\$ 82,176	\$		\$ 699,902	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	Resident Transportation	1998 Ford 20 Pass. Bus	1998	\$ 56,554	\$	\$	\$	5	\$ 56,554	76
77	Resident Transportation	1989 Ford Van	1990	29,170				5	29,170	77
78	Resident Transportation	1998 Dodge Caravan	2003	10,000	2,167	2,167		5	4,500	78
79										79
80	TOTALS			\$ 95,724	\$ 2,167	\$ 2,167	\$		\$ 90,224	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)		\$ 8,314,894	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 305,167	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 305,167	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)		\$ 4,302,264	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	I/L Resident Buildings-1979	\$ 7,445,036	\$ 94,662	\$ 6,125,686	86
87	Admin. Building-1983	195,948	2,920	152,154	87
88	Admin. Building Renovation-1994	1,568,510	35,051	236,996	88
89	Non LTC Building Costs	1,645,061	23,060	1,292,149	89
90	Non LTC Equipment and Vehicles	3,477,160	178,295	2,682,264	90
91	TOTALS	\$ 14,331,715	\$ 333,988	\$ 10,489,249	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning: 01/01/06

Ending: 12/31/06

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					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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>
--	---	--

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)	
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.

Facility Name & ID Number Friendship Manor# 0024760

Report Period Beginning:

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	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	9	4773 hrs	286,385				4,773	286,385	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	TOTAL			\$ 286,385		\$	\$	4,773	\$ 286,385	14

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

Facility Name & ID Number Friendship Manor# 0024760Report Period Beginning: 01/01/06

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	865,613		3
4	Supply Inventory (priced at)	118,037		4
5	Short-Term Investments	88,236		5
6	Prepaid Insurance	239,920		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	19,055		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,330,861	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	40,284		11
12	Long-Term Investments	4,356,496		12
13	Land	252,793		13
14	Buildings, at Historical Cost	16,783,640		14
15	Leasehold Improvements, at Historical Cost	417,847		15
16	Equipment, at Historical Cost	5,192,328		16
17	Accumulated Depreciation (book methods)	(14,791,510)		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):	444,002		22
23	Other(specify):	263,322		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,959,202	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,290,063	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 857,736	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,026,391		29
30	Accrued Salaries Payable	411,039		30
31	Accrued Taxes Payable (excluding real estate taxes)	79,234		31
32	Accrued Real Estate Taxes(Sch.IX-B)	168,277		32
33	Accrued Interest Payable	(125,375)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		32,250		36
37		9,438		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,458,990	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,847,953		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		2,573,676		43
44		1,860,782		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,282,411	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,741,401	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 548,662	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,290,063	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (128,228)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (128,228)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	676,890	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)	\$ 676,890	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)	\$ 548,662	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,867,037	1
2	Discounts and Allowances for all Levels	(160,394)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,706,643	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	35,322	13
14	Non-Patient Meals	355,705	14
15	Telephone, Television and Radio	63,501	15
16	Rental of Facility Space	86,711	16
17	Sale of Drugs	182,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	47,289	21
22	Laundry	122,778	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 893,507	23
D. Non-Operating Revenue			
24	Contributions	406,258	24
25	Interest and Other Investment Income***	372,248	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 778,506	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		775,027	28
28a		1,403,706	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,178,733	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,557,389	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,467,849	31
32	Health Care	2,659,821	32
33	General Administration	2,441,739	33
B. Capital Expense			
34	Ownership	1,270,651	34
C. Ancillary Expense			
35	Special Cost Centers	11,742	35
36	Provider Participation Fee	28,697	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,880,499	40
41	Income before Income Taxes (line 30 minus line 40)**	676,890	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 676,890	43

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

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

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

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

Facility Name & ID Number Friendship Manor

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Report Period Beginning:

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12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,480	1,708	\$ 62,333	\$ 36.49	1
2	Assistant Director of Nursing	1,960	2,080	53,997	25.95	2
3	Registered Nurses	7,993	8,679	177,852	20.49	3
4	Licensed Practical Nurses	23,224	25,609	448,317	17.51	4
5	CNAs & Orderlies	84,583	94,156	1,040,786	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,918	4,710	78,573	16.68	9
10	Activity Assistants	7,169	7,831	76,194	9.73	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,696	1,744	62,345	35.75	13
14	Head Cook	1,920	2,080	47,022	22.61	14
15	Cook Helpers/Assistants	52,932	58,948	598,366	10.15	15
16	Dishwashers					16
17	Maintenance Workers	18,719	21,309	209,475	9.83	17
18	Housekeepers	27,216	30,611	293,423	9.59	18
19	Laundry	5,794	6,334	52,888	8.35	19
20	Administrator	2,016	2,104	154,491	73.43	20
21	Assistant Administrator	1,848	2,104	75,321	35.80	21
22	Other Administrative	9,719	10,926	290,994	26.63	22
23	Office Manager	1,872	2,104	69,435	33.00	23
24	Clerical	12,387	13,610	184,198	13.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,131	1,241	13,288	10.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,577	297,888	\$ 3,989,298 *	\$ 13.39	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	1,000	16,895	10	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,000	\$ 16,895		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 Manor

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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (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. \$ 28,697
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Eide Bailly, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.