

Facility Name & ID Number Friendship House of Centralia# 0045682 Report Period Beginning: 1/1/07 Ending: 12/31/07

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>19</u>	Skilled (SNF)	<u>19</u>	<u>6,935</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>75</u>	Intermediate (ICF)	<u>75</u>	<u>27,375</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</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>669</u>	<u>80</u>	<u>3,451</u>	<u>4,200</u>	8
9	SNF/PED					9
10	ICF	<u>15,975</u>	<u>2,384</u>	<u>327</u>	<u>18,686</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,644</u>	<u>2,464</u>	<u>3,778</u>	<u>22,886</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.70%

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)

N/AF. 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 1/29/2002

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

YES Date 1/29/2002 NO

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

YES NO If YES, enter number of beds certified 19 and days of care provided 3,334Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	127,761	6,405	8,189	142,355		142,355		142,355		1
2	Food Purchase		120,604		120,604		120,604	(2,992)	117,612		2
3	Housekeeping	67,206	13,069	(1,439)	78,836		78,836		78,836		3
4	Laundry	51,332	9,923		61,255		61,255		61,255		4
5	Heat and Other Utilities			103,139	103,139		103,139		103,139		5
6	Maintenance	30,750	11,108	14,603	56,461		56,461		56,461		6
7	Other (specify):* Trash Removal			8,068	8,068	2,657	10,725		10,725		7
8	TOTAL General Services	277,049	161,109	132,560	570,718	2,657	573,375	(2,992)	570,383		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	931,765	54,913	5,792	992,470	(2,657)	989,813		989,813		10
10a	Therapy	167,751	1,251	(53,031)	115,971		115,971		115,971		10a
11	Activities	36,722	3,031	2,442	42,195		42,195		42,195		11
12	Social Services	31,367		2,042	33,409		33,409		33,409		12
13	CNA Training										13
14	Program Transportation			340	340		340	(340)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,167,605	59,195	(32,815)	1,193,985	(2,657)	1,191,328	(340)	1,190,988		16
	C. General Administration										
17	Administrative	66,473			66,473	3,361	69,834		69,834		17
18	Directors Fees										18
19	Professional Services			204,188	204,188		204,188	(201,366)	2,822		19
20	Dues, Fees, Subscriptions & Promotions			12,413	12,413	897	13,310	(7,537)	5,773		20
21	Clerical & General Office Expenses	107,491	10,522	64,960	182,973	(4,258)	178,715	24,764	203,479		21
22	Employee Benefits & Payroll Taxes			306,481	306,481		306,481	88,944	395,425		22
23	Inservice Training & Education			1,041	1,041		1,041	302	1,343		23
24	Travel and Seminar			1,190	1,190		1,190	345	1,535		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			66,682	66,682		66,682	19,352	86,034		26
27	Other (specify):*			(49,707)	(49,707)		(49,707)	49,707			27
28	TOTAL General Administration	173,964	10,522	607,248	791,734		791,734	(25,489)	766,245		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,618,618	230,826	706,993	2,556,437		2,556,437	(28,821)	2,527,616		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 House of Centralia #0045682 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			39,657	39,657	39,657	3,334	42,991			30
31	Amortization of Pre-Op. & Org.			25,935	25,935	25,935	1,777	27,712			31
32	Interest			91,606	91,606	91,606	6,214	97,820			32
33	Real Estate Taxes			17,620	17,620	17,620	1,207	18,827			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			7,814	7,814	7,814	535	8,349			35
36	Other (specify):*										36
37	TOTAL Ownership			182,632	182,632	182,632	13,067	195,699			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			600	600	600	(600)				38
39	Ancillary Service Centers		148,624	3,553	152,177	152,177	772	152,949			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			51,465	51,465	51,465		51,465			42
43	Other (specify):* Rad/Lab Consult			10,814	10,814	10,814		10,814			43
44	TOTAL Special Cost Centers		148,624	66,432	215,056	215,056	172	215,228			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,618,618	379,450	956,057	2,954,125	2,954,125	(15,582)	2,938,543			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 House of Centralia

0045682

Report Period Beginning: 1/1/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,992)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(61)	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)	(106)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28,337)	21		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	41,637	27		24
25	Fund Raising, Advertising and Promotional	(11,139)	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	7,543			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 6,545		\$	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)	(22,127)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,127)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (15,582)		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 House of Centralia

ID# 0045682

Report Period Beginning: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Prior Year Expense	\$ 8,176	27	1
2	Prior Year Ancillary Expense	(311)	39	2
3	G/L on Asset Disposal	618	30	3
4	Non-Medical Transport	(340)	14	4
5	Medical Transport	(600)	38	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	7,543		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	(2,992)	0	0	0	0	0	0	0	0	0	0	(2,992)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,992)	0	0	0	0	0	0	0	0	0	0	(2,992)	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	(340)	0	0	0	0	0	0	0	0	0	0	(340)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(340)	0	0	0	0	0	0	0	0	0	0	(340)	16
	C. General Administration													
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	(201,366)	0	0	0	0	0	0	0	0	0	(201,366)	19
20	Fees, Subscriptions & Promotions	(11,139)	3,602	0	0	0	0	0	0	0	0	0	(7,537)	20
21	Clerical & General Office Expenses	(28,337)	53,101	0	0	0	0	0	0	0	0	0	24,764	21
22	Employee Benefits & Payroll Taxes	0	88,944	0	0	0	0	0	0	0	0	0	88,944	22
23	Inservice Training & Education	0	302	0	0	0	0	0	0	0	0	0	302	23
24	Travel and Seminar	0	345	0	0	0	0	0	0	0	0	0	345	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	19,352	0	0	0	0	0	0	0	0	0	19,352	26
27	Other (specify):*	49,707	0	0	0	0	0	0	0	0	0	0	49,707	27
28	TOTAL General Administration	10,231	(35,720)	0	(25,489)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	6,899	(35,720)	0	(28,821)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	618	2,716	0	0	0	0	0	0	0	0	0	3,334	30
31	Amortization of Pre-Op. & Org.	0	1,777	0	0	0	0	0	0	0	0	0	1,777	31
32	Interest	(61)	6,275	0	0	0	0	0	0	0	0	0	6,214	32
33	Real Estate Taxes	0	0	1,207	0	0	0	0	0	0	0	0	1,207	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	535	0	0	0	0	0	0	0	0	535	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	557	10,768	1,742	0	13,067	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(600)	0	0	0	0	0	0	0	0	0	0	(600)	38
39	Ancillary Service Centers	(311)	1,083	0	0	0	0	0	0	0	0	0	772	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	(911)	1,083	0	0	0	0	0	0	0	0	0	172	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,545	(23,869)	1,742	0	(15,582)	45							

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
LTC of Illinois-Friendship, Inc.	100	LYC of Illinois - Fireside, Inc.	Centralia	AltaCare Corp.	Alpharetta	LTC Mgt/Accting
				HP/Ancillaries	Alpharetta	MED/Dietary Suppli

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Management Fees	\$ 172,001	AltaCare Corporation	100.00%	\$	\$ (172,001)	1
2	V	19 Accounting Fees	30,000	AltaCare Corporation	100.00%		(30,000)	2
3	V	39 Medical Supplies	4,238	HP/Ancillaries	100.00%	5,321	1,083	3
4	V	19 Non-Related Professional Svc		AltaCare Corporation	100.00%	635	635	4
5	V	20 Dues, Fees, Subs and Promos		AltaCare Corporation	100.00%	3,602	3,602	5
6	V	21 Clerical & Gen Office Exp		AltaCare Corporation	100.00%	53,101	53,101	6
7	V	22 Employee Benefits & Taxes		AltaCare Corporation	100.00%	88,944	88,944	7
8	V	23 Training & Education		AltaCare Corporation	100.00%	302	302	8
9	V	24 Travel & Seminars		AltaCare Corporation	100.00%	345	345	9
10	V	26 Liability Insurance		AltaCare Corporation	100.00%	19,352	19,352	10
11	V	30 Depreciation		AltaCare Corporation	100.00%	2,716	2,716	11
12	V	31 Amortization		AltaCare Corporation	100.00%	1,777	1,777	12
13	V	32 Non Related Interest		AltaCare Corporation	100.00%	6,275	6,275	13
14	Total		\$ 206,239			\$ 182,370	\$ * (23,869)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	\$	AltaCare Corporation	100.00%	\$ 1,207	\$ 1,207	15
16	V	35	Rent Equipment and Vehicles		AltaCare Corporation	100.00%	535	535	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 1,742	\$ * 1,742	39

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

Facility Name & ID Number Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending: 12/31/07

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 AltaCare Corporation
 Street Address 925 North Point Pkwy, Suite 440
 City / State / Zip Code Alpharetta, GA, 30005
 Phone Number (770-619-0866
 Fax Number (770-619-0262

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	19	Management Fees	Total Expense	45	\$ 6,478,472	\$ 4,113,670	2,752,122	\$ 166,281	1
2	32	Capital	Total Expense	45	487,412		2,752,122	12,510	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				\$ 6,965,884	\$ 4,113,670		\$ 178,791	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	Name of Lender	2		3	4	5	6		8	9	10						
		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	GMAC		X	Facility Mortgage		1/25/02	\$ 550,000	\$	1/25/07	7.7500	\$ 37,725	1					
2	Zeigler Healthcare		X	Refinancing Mortgage	variable	8/31/07	1,195,927	1,182,921	8/20/2012	Variable	41,952	2					
3												3					
4												4					
5												5					
Working Capital																	
6	Zeigler Healthcare		X	AR financing	\$6,404.00	8/19/2007	149,860	149,242	8/20/2012	15.0000	7,873	6					
7	Insurance		X	Liability & Worker's Comp			variable			Variable	4,056	7					
8												8					
9	TOTAL Facility Related					\$6,404.00	\$ 1,895,787	\$ 1,332,163			\$ 91,606	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 1,895,787	\$ 1,332,163			\$ 91,606	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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	35,241 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	35,241 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	35,241 12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045682

CONTACT PERSON REGARDING THIS REPORT Daren Douston

TELEPHONE 770-870-2859 FAX #: 770-619-0262

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>14-17-000-068</u>	<u>Strip 17ft x 678ft off W side of part SV</u>	\$ <u>28.72</u>	\$ _____
2. <u>14-17-000-059</u>	<u>W1/2 W 6 A SW NE NW tract 1&2</u>	\$ <u>34,889.20</u>	\$ _____
3. <u>14-17-000-056</u>	<u>S PT E 66ft SE NW NW Tract 6</u>	\$ <u>167.14</u>	\$ _____
4. <u>14-17-000-005</u>	<u>N PT E 66 FT SE NW NW Tracts 3&4</u>	\$ <u>155.88</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>35,240.94</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 X 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,100 B. General Construction Type: Exterior Brick & Block Frame Masonry 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: 46,825 2. Number of Years Over Which it is Being Amortized: \$21825 5 yrs/\$25K 30 yrs
3. Current Period Amortization: 850 4. Dates Incurred: 2002

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>LTC</u>	<u>174,240</u>	<u>2002</u>	<u>\$ 22,915</u>	1
2					2
3	TOTALS	174,240		\$ 22,915	3

Facility Name & ID Number Friendship House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	98		2002	1965	\$ 965,160	\$ 24,129	40	\$ 24,129	\$	\$ 142,763	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Parking lot Resurfacing- Howell Asphalt		2002	31,694	2,113	15	2,113		11,445	9
10		250ft Sidewalk-JR Construction		2005	4,300	287	15	287		597	10
11		75ft fence on E side-Consolidated Fence		2007	2,175	60	15	60		60	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 House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending:

12/31/07

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)	\$ 1,003,329	\$ 26,589		\$ 26,589	\$	\$ 154,866	70

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

Facility Name & ID Number Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 91,086	\$ 11,611	\$ 11,611	\$	5,7&10	\$ 63,317	71
72	Current Year Purchases	6,197	307	307		10	307	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 97,283	\$ 11,918	\$ 11,918	\$		\$ 63,624	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 Trips	Intl Thomas Bus 1995	2005	\$ 5,750	\$ 1,150	\$ 1,150	\$	5	\$ 2,492	76
77										77
78										78
79										79
80	TOTALS			\$ 5,750	\$ 1,150	\$ 1,150	\$		\$ 2,492	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)	\$ 1,129,277	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,657	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,657	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)	\$ 220,981	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					_____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A-1&2	1496	hrs	\$ 48,288		\$	519		1,496	\$ 48,807	1
2	Licensed Speech and Language Development Therapist	10A-1&2	1019	hrs	30,060			64		1,019	30,124	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10A-1&2	2961	hrs	89,402			668		2,961	90,070	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy			# of prescripts								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				\$ 167,750		\$	1,251		5,476	\$ 169,001	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 House of Centralia# 0045682Report Period Beginning: 1/1/07Ending: 12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (13,457)	\$	1
2	Cash-Patient Deposits	16,117		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	403,722		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,325		6
7	Other Prepaid Expenses	2,185		7
8	Accounts Receivable (owners or related parties)	(1,848,148)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,428,256)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,914		13
14	Buildings, at Historical Cost	965,160		14
15	Leasehold Improvements, at Historical Cost	38,169		15
16	Equipment, at Historical Cost	114,068		16
17	Accumulated Depreciation (book methods)	(232,635)		17
18	Deferred Charges	44,667		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	149,034		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,101,377	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (326,879)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 525,145	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,117		28
29	Short-Term Notes Payable	38,753		29
30	Accrued Salaries Payable	135,279		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,521		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,645		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Acrued Bed Tax</u>	12,972		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 826,432	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	149,242		39
40	Mortgage Payable	1,182,921		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,332,163	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,158,595	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,485,474)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (326,879)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,398,036)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,398,036)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(87,445)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) rounding	7	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (87,438)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,485,474)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Friendship House of Centralia# 0045682Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 2,610,718	1
2	Discounts and Allowances for all Levels	194,882	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,805,600	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	58,312	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 58,312	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,992	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(6)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	341	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,326	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(557)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (557)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,866,680	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	570,719	31
32	Health Care	1,193,984	32
33	General Administration	791,734	33
B. Capital Expense			
34	Ownership	182,633	34
C. Ancillary Expense			
35	Special Cost Centers	163,590	35
36	Provider Participation Fee	51,465	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,954,125	40
41	Income before Income Taxes (line 30 minus line 40)**	(87,445)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (87,445)	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 House of Centralia

0045682

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	1,848	2,080	\$ 69,427	\$ 33.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,301	8,623	180,015	20.88	3
4	Licensed Practical Nurses	12,299	14,140	233,168	16.49	4
5	CNAs & Orderlies	40,189	46,206	415,605	8.99	5
6	CNA Trainees					6
7	Licensed Therapist	4,911	5,476	167,750	30.63	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,440	4,009	36,722	9.16	10
11	Social Service Workers	1,823	2,124	31,367	14.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,942	13,834	127,761	9.24	15
16	Dishwashers					16
17	Maintenance Workers	2,858	3,140	30,750	9.79	17
18	Housekeepers	7,406	8,566	67,206	7.85	18
19	Laundry	5,832	6,597	51,332	7.78	19
20	Administrator	1,979	2,080	71,713	34.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,397	6,870	102,251	14.88	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	1,833	2,255	25,668	11.38	31
32	Other Health C: <u>Central Supply</u>	627	627	7,882	12.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	109,685	126,627	\$ 1,618,617 *	\$ 12.78	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	195	\$ 8,189	1-3	35
36	Medical Director		9,600	9-3	36
37	Medical Records Consultant	42	2,075	10-3	37
38	Nurse Consultant		549	10-3	38
39	Pharmacist Consultant		3,242	39-3	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	2,442	11-3	44
45	Social Service Consultant	37	2,042	12-3	45
46	Other(specify) <u>Non-Med Trans Svc</u>		340	14-3	46
47	<u>Med-transport svc</u>		600	38-3	47
48	<u>Lab/Radiology</u>		10,814	43-3	48
49	TOTAL (lines 35 - 48)	318	\$ 39,893		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

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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	
Kathy Berck			\$ 71,713	Workers' Compensation Insurance	\$ 100,678	IDPH License Fee	\$ 1,097	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	177	
				FICA Taxes	183,066	Health Care Worker Background Check	897	
				Employee Health Insurance	16,250	(Indicate # of checks performed <u>32</u>)		
				Employee Meals		Dues	6,563	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	4,576	
				Appreciation/Holiday Party	3,817			
				Dental	(22)	Less: Public Relations Expense	(6,563)	
				Life	2,997	Non-allowable advertising	(4,576)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 71,713	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 306,786		\$ 2,171		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
							Nursing Travel	322
							Activities & Soc Svc Travel	391
							A&G/Facility Travel	352
							Seminar Expense	125
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	
Vendor/Payee	Type	Amount					\$ 1,190	
AltaCare Corp	Management Services	\$ 172,001						
AltaCare Corp	Accounting Services	30,000						
Payday USA Inc.	Payroll Processing	2,018						
CT Corp	Registered Agent	169						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 204,188					
(If total legal fees exceed \$5,000, 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? YES
If YES, give association name and amount. IHCA-\$6110
- (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? 5,7&10
- (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 _____ 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. \$ 51,465
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.