

		FOR BHF USE					

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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
<b>IRS Exemption Code</b> _____	<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) 794-4108

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Ted Pappas</u>	
	(Title) <u>CEO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Gwen A. Moser Partner</u>	
	(Firm Name & Address) <u>Eide Bailly, LLP 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: 01/01/07 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>63</u>	Skilled (SNF)	<u>73</u>	<u>26,055</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>12,410</u>	5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>107</u>	<u>38,465</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>5,033</u>	<u>16,427</u>	<u>3,954</u>	<u>25,414</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>9,019</u>	<u>0</u>	<u>9,019</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,033</u>	<u>25,446</u>	<u>3,954</u>	<u>34,433</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.52%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

YES  NO

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

YES  NO

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

Date started 06/29/79

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 73 and days of care provided 3,828

Medicare 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: 01/01/07 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	
	<b>A. General Services</b>											
1	Dietary	792,739	693,562	94,894	1,581,195		1,581,195	(1,100,991)	480,204			1
2	Food Purchase											2
3	Housekeeping	309,294	43,986	9,979	363,259		363,259		363,259			3
4	Laundry	64,092	47,503	4,981	116,576		116,576	(13,136)	103,440			4
5	Heat and Other Utilities			329,536	329,536		329,536		329,536			5
6	Maintenance	210,927	86,243	117,057	414,227		414,227	(829,915)	(415,688)			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>1,377,052</b>	<b>871,294</b>	<b>556,447</b>	<b>2,804,793</b>		<b>2,804,793</b>	<b>(1,944,042)</b>	<b>860,751</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	2,024,471	212,516	747,144	2,984,131		2,984,131		2,984,131			10
10a	Therapy											10a
11	Activities	177,026	31,472	38,301	246,799		246,799		246,799			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,201,497</b>	<b>243,988</b>	<b>785,445</b>	<b>3,230,930</b>		<b>3,230,930</b>		<b>3,230,930</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	363,296	30,540	375,243	769,079		769,079	(594,988)	174,091			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			92,550	92,550		92,550		92,550			20
21	Clerical & General Office Expenses	611,050		184,585	795,635		795,635		795,635			21
22	Employee Benefits & Payroll Taxes			1,030,658	1,030,658		1,030,658	(94,396)	936,262			22
23	Inservice Training & Education											23
24	Travel and Seminar			43,057	43,057		43,057		43,057			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			333,106	333,106		333,106		333,106			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>974,346</b>	<b>30,540</b>	<b>2,059,199</b>	<b>3,064,085</b>		<b>3,064,085</b>	<b>(689,384)</b>	<b>2,374,701</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,552,895</b>	<b>1,145,822</b>	<b>3,401,091</b>	<b>9,099,808</b>		<b>9,099,808</b>	<b>(2,633,426)</b>	<b>6,466,382</b>			<b>29</b>

\*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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			699,783	699,783		699,783	(571,985)	127,798		30
31	Amortization of Pre-Op. & Org.			23,017	23,017		23,017		23,017		31
32	Interest			480,381	480,381		480,381	(157,692)	322,689		32
33	Real Estate Taxes			152,070	152,070		152,070		152,070		33
34	Rent-Facility & Grounds			52,636	52,636		52,636		52,636		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,407,887	1,407,887		1,407,887	(729,677)	678,210		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops			17,016	17,016		17,016		17,016		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,089	38,089		38,089		38,089		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			55,105	55,105		55,105		55,105		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,552,895	1,145,822	4,864,083	10,562,800		10,562,800	(3,363,103)	7,199,697		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: 01/01/07

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				4
5	Telephone, TV & Radio in Resident Rooms	(40,345)	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	(157,692)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13,401)	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	(26,531)	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	(155,714)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (393,683)		\$	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	(2,969,420)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,969,420)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (3,363,103)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Friendship Manor

ID# 0024760

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Depreciation	\$ (571,985)	30	1
2	Employee Benefits	(94,396)	22	2
3	Administrative & General	(399,342)	17	3
4	Maintenance	(789,570)	6	4
5	Laundry	(13,136)	4	5
6	Dietary	(1,100,991)	1	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	<b>Total</b>	(2,969,420)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

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)	
	<b>A. General Services</b>													
1	Dietary	(1,100,991)	0	0	0	0	0	0	0	0	0	0	(1,100,991)	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	(13,136)	0	0	0	0	0	0	0	0	0	0	(13,136)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(829,915)	0	0	0	0	0	0	0	0	0	0	(829,915)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,944,042)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,944,042)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(594,988)	0	0	0	0	0	0	0	0	0	0	(594,988)	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	(94,396)	0	0	0	0	0	0	0	0	0	0	(94,396)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(689,384)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(689,384)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,633,426)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,633,426)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	(571,985)	0	0	0	0	0	0	0	0	0	0	(571,985)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(157,692)	0	0	0	0	0	0	0	0	0	0	(157,692)	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	<b>TOTAL Ownership</b>	<b>(729,677)</b>	<b>0</b>	<b>(729,677)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(3,363,103)</b>	<b>0</b>	<b>(3,363,103)</b>	<b>45</b>									

Facility Name & ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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: 01/01/07 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 Manor

# 0024760

Report Period Beginning: 01/01/07

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 \_\_\_\_\_  
 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

Facility Name & ID Number Friendship Manor # 0024760 Report Period Beginning: 01/01/07 Ending: 12/31/07

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Series 2004 Revenue Bonds		X	Renovation	\$44,000.00	11/2004	\$ 6,345,000	\$ 5,785,000	11/2024	6.0000	\$ 343,358	1								
2	American Bank Note		X	Operations and Capital Improv	\$34,934.00	07/2007	4,000,000	3,972,215	07/2012	8.2500	137,023	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$78,934.00		\$ 10,345,000	\$ 9,757,215			\$ 480,381	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 10,345,000	\$ 9,757,215			\$ 480,381	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:** 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 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 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>10-345-07-00</u>	<u>Various</u>	\$ <u>973.96</u>	\$ _____
2. <u>10-325-18-90</u>	<u>Various</u>	\$ <u>155,711.12</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>156,685.08</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 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 Manor

# 0024760 Report Period Beginning:

01/01/07 Ending:

12/31/07

**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).

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

1. Total Amount Incurred: \_\_\_\_\_ 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>11</u>	<u>1973</u>	<u>\$ 252,793</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>11</b>		<b>\$ 252,793</b>	<b>3</b>

Facility Name &amp; ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	\$ 25,638	40	\$ 25,638	\$	\$ 1,540,789	4
5	34		1985	1985	2,286,316	37,440	40	37,440		1,631,108	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10		Building Improvements for 1994		1994	6,283	419	Various	419		5,900	10
11		Building Improvements for 1995		1995			Various				11
12		Building Improvements for 1996		1996			Various				12
13		Building Improvements for 1997		1997	68,766	3,722	Various	3,722		40,057	13
14		Building Improvements for 1998		1998	81,587	4,026	Various	4,026		40,486	14
15		Building Improvements for 1999		1999	20,215	1,011	Various	1,011		8,845	15
16		Building Improvements for 2000		2000	68,858	4,152	Various	4,152		34,016	16
17		Building Improvements for 2001		2001	58,930	4,341	Various	4,341		30,691	17
18		Building Improvements for 2002		2002	27,010	3,915	Various	3,915		22,618	18
19		Building Improvements for 2003		2003	153,522	10,253	Various	10,253		40,978	19
20		Mainstreet Auto Sprinkler System		2004	47,924	1,917	25	1,917		3,994	20
21		Mainstreet Ductwork, Diffusers, Air Intaker, Grille		2004	7,400	493	15	493		1,027	21
22		Mainstreet Wall Panel / Cornice		2004	3,884	777	5	777		1,619	22
23		Minstreet Auto Sprinkler Flow/Tamper Switches		2004	2,270	151	15	151		315	23
24		Mainstreet Recessed Lighting		2004	897	60	15	60		125	24
25		Mainstreet Interiors		2004	1,493	100	15	100		208	25
26		Roof-A Bldg		2004	19,208	1,281	15	1,281		5,336	26
27		Mainstreet Plumbing/Piping		2004	26,144	1,307	20	1,307		2,723	27
28		Mainstreet New Windows/Patio Sliders		2004	13,001	867	15	867		1,806	28
29		Mainstreet Doors/Old Time Closet Doors		2004	5,173	345	15	345		719	29
30		Asphalt-C Bldg West		2004	1,935	645	3	645		2,523	30
31		Mainstreet Cap Const. Cost-Internal Labor		2004	60,000	4,000	15	4,000		8,333	31
32		Mainstreet Project Supplies		2004	2,585	172	15	172		359	32
33		Mainstreet Project Supplies/Equipment		2004	4,225	282	15	282		587	33
34		B & D Building Handrails		2004	5,140	1,028	5	1,028		4,026	34
35		Mainstreet Library Floor Covering		2004	4,121	824	5	824		1,717	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 &amp; ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	Roof -A Bldg	2004	\$ 67,483	\$ 4,499		\$ 4,499	\$	\$ 17,621	37
38	Mainstreet Doors Library/Exercise	2004	2,076	104		104		216	38
39	Mainstreet Fire Alarm System	2004	2,435	243		243		507	39
40	Bldg Repair Project-New Butterfly Valves	2004	2,365	118		118		246	40
41	Mainstreet Exercise/American Bank Doors	2004	3,892	259		259		540	41
42	Roof- C Bldg	2004	63,017	4,201		4,201		14,354	42
43	Mainstreet Windows/Fitness Room Mirrors	2005	1,111	74		74		154	43
44	Water Tanks	2005	48,650	2,433		2,433		8,312	44
45	Office Construction Administration	2005	43,488	2,899		2,899		9,664	45
46	Cooling Tower Installation	2005	23,599	2,360		2,360		7,670	46
47	Board Room Construction	2005	11,606	774		774		2,515	47
48	Mainstreet Ducts, Diffusers, Grillers, Air Intakes	2005	1,649	110		110		229	48
49	Mainstreet Bank Floor Covering	2005	4,169	834		834		1,737	49
50	Fire Dampers Sheltered Care	2005	59,920	2,996		2,996		9,737	50
51	Mainstreet Project Doors/Supplies	2005	2,320	155		155		323	51
52	Boiler Upgrade	2005	77,938	3,897		3,897		12,340	52
53	Mainstreet Project Supplies	2005	1,600	107		107		223	53
54	Mainstreet Project Supplies	2005	731	49		49		102	54
55	Mainstreet Project Supplies	2005	10,371	691		691		1,440	55
56	Mainstreet-Cap Constr Costs Internal Labor	2005	30,116	2,008		2,008		4,183	56
57	Roof-BBldg Admin Bldg, Boiler/Garage	2005	159,605	10,640		10,640		34,036	57
58	Doors-Mainstreet Old Town Mall	2005	4,281	285		285		594	58
59	Architect Fees For Bed Conversion	2005	7,036	704		704		2,053	59
60	B-217/B-104 Cabinets/Countertops	2005	3,648	243		243		709	60
61	Roof Nursing/Activities Center	2005	97,595	9,760		9,760		28,466	61
62	Concrete Ramp A Bldg North Side	2005	7,560	504		504		1,428	62
63	Sprinkler System	2005	87,265	3,491		3,491		7,272	63
64	Storage Garage North Side Bldg A	2005	37,003	2,467		2,467		6,924	64
65	Remodel A Bldg-Fire Alarm/Nurse Call System	2005	77,815	7,782		7,782		21,675	65
66	Mainstreet Project-Supplies	2005	133,277	8,885		8,885		18,511	66
67	Fire Dampers Complete SC	2005	6,900	690		690		1,610	67
68	Storage Garage Platform Complete w/ 0146001438	2006	2,600	173		173		433	68
69	Mainstreet Project Supplies	2006	105,366	7,024		7,024		14,634	69
70	TOTAL (lines 4 thru 69)		\$ 6,026,633	\$ 190,625		\$ 190,625	\$	\$ 3,661,363	70

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

Facility Name &amp; ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

Ending:

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**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,026,633	\$ 190,625		\$ 190,625	\$	\$ 3,661,363	1
2	Mainstreet Project Supplies	2006	57,946	3,863		3,863		8,048	2
3	B122 New Patio Sliders	2006	1,552	103		103		241	3
4	C201 New Patio Sliders	2006	1,552	103		103		241	4
5	Mainstreet Project Supplies	2006	34,712	2,314		2,314		4,821	5
6	Mainstreet Project Supplies	2006	1,099	73		73		152	6
7	Call System/Fire Alarm	2006	20,105	2,010		2,010		4,188	7
8	Mainstreet Country Store Sliding Door	2006	2,423	162		162		337	8
9	Mainstreet Project Supplies	2006	21,214	1,414		1,414		2,946	9
10	Special Project Building	2006	14,845	990		990		2,062	10
11	Mainstreet Capital Const Costs Internal Labor	2006	69,334	4,622		4,622		9,629	11
12	Mainstreet Project	2006	26,406	1,760		1,760		3,520	12
13	Bridge For East Entrance B Bldg	2006	26,089	1,594		1,594		3,188	13
14	Shower Base, Kitchen Sink	2006	1,622	81		81		162	14
15	Cooling Tower Motor (Computer)	2006	1,725	345		345		690	15
16	C101 Patio Slider Door	2006	1,757	117		117		234	16
17	Stairs/Sidewalk Between A&B Bldg	2006	17,685	1,179		1,179		2,358	17
18	Nurse Call System Alarm/Detect tes	2006	8,944	820		820		1,640	18
19	Landscaping Culvers Lawn & Landscape	2006	4,345	362		362		724	19
20	Receptacles-GFI Weatherproof (13)	2006	2,630	175		175		307	20
21	Electrical Boxes For All Bldgs-out	2006	1,416	94		94		165	21
22	Bridge Bldg B East	2006	2,899	129		129		225	22
23	Clinic (3) Baths Vinyl	2007	685	137		137		137	23
24	Remodel A Bldg - Fire Alarm/Nurse Call	2007	4,350	363		363		363	24
25	Blower Motors	2007	1,442	72		72		72	25
26	Remodel Employee Lounge	2007	1,081	63		63		63	26
27	Remodel Sheltered Care	2007	14,624	853		853		853	27
28	B Building Remodel	2007	21,742	1,268		1,268		1,268	28
29	Remodel Marketing Office	2007	2,988	349		349		349	29
30	Mainstreet Project Supplies	2007	7,513	292		292		292	30
31	Apartment Remodeling - Internal Labor	2007	118,214	3,448		3,448		3,448	31
32	Door Alarms	2007	140,935	8,221		8,221		8,221	32
33	CON Project - Carpet	2007	2,074	242		242		242	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,662,581	\$ 228,243		\$ 228,243	\$	\$ 3,722,549	34

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

Facility Name &amp; ID Number Friendship Manor

# 0024760

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,662,581	\$ 228,243		\$ 228,243	\$	\$ 3,722,549	1
2	CON Project - Automatic Doors	2007	23,270	1,357		1,357		1,357	2
3	CON Project - HAVAC & A/C	2007	27,352	1,064		1,064		1,064	3
4	Apartment Remodeling - Building	2007	126,154	3,680		3,680		3,680	4
5	Door and Door Closures	2007	3,963	231		231		231	5
6	C Building Ramp Reslope	2007	3,407	106		106		106	6
7	Elevator Carpet	2007	636	53		53		53	7
8	New S/C Room Electrical	2007	1,200	33		33		33	8
9	B322 New Slider Patio Door	2007	1,942	54		54		54	9
10	D203 New Slider Patio Door	2007	1,942	54		54		54	10
11	Interiors Kitchen, Dining, Lobby	2007	6,643	443		443		443	11
12	Beauty Shop Furniture	2007	1,125	75		75		75	12
13	Mansard Roof 685 Square Feet	2007	4,795	160		160		160	13
14	Overhead Garage Door	2007	3,791	126		126		126	14
15	Rebuilt Heat Exchanger	2007	3,945	99		99		99	15
16	C Bldg Ramp	2007	1,000	167		167		167	16
17	Rebuilt Generator Inject Pump	2007	1,698	85		85		85	17
18	Overhead Door Platform	2007	771	19		19		19	18
19	Receptacles Beauty Shop	2007	2,057	51		51		51	19
20	New Windows	2007	1,832	31		31		31	20
21	A303 New Slider Patio Door	2007	1,830	20		20		20	21
22	Vinyl Beauty Shop Req 50	2007	1,661	55		55		55	22
23	New Garage Heater - MNTC Gar	2007	1,867	31		31		31	23
24	Building Remodel - Internal Labor	2007	62,439	260		260		206	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,947,901	\$ 236,497		\$ 236,497	\$	\$ 3,730,749	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: 01/01/07 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	\$ 1,534,234	\$ 86,203	\$ 86,203	\$		\$ 704,360	71
72	Current Year Purchases	44,982	2,207	2,207			2,207	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,579,216	\$ 88,410	\$ 88,410	\$		\$ 706,567	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	4,000	4,000		5	8,500	78
79	Resident Transportation	2007 Econoline Van	2007	60,450	3,778	3,778		4	3,778	79
80	TOTALS			\$ 156,174	\$ 7,778	\$ 7,778	\$		\$ 98,002	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)		\$ 8,936,084	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 332,685	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 332,685	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)		\$ 4,535,318	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 Building-1979	\$ 7,445,036	\$ 102,550	\$ 6,163,155	86
87	Admin Building-1983	195,948	2,920	153,613	87
88	Admin Building-1983	1,568,510	35,051	639,666	88
89	Non LTC Building Costs	1,218,680	19,241	685,598	89
90	Non LTC Equipment and Vehicles	3,378,218	207,288	2,473,297	90
91	TOTALS	\$ 13,806,392	\$ 367,050	\$ 10,115,329	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: 01/01/07

Ending: 12/31/07

**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	<b>TOTAL</b>				\$ _____			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	<b>TOTAL</b>		\$ _____	\$ _____	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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Friendship Manor# 0024760

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	10	6473 hrs	458,323				6,473	458,323	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			\$ 458,323		\$	\$	6,473	\$ 458,323	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: 01/01/07

Ending:

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 7,341	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>13,720</u> )	788,507		3
4	Supply Inventory (priced at )	157,190		4
5	Short-Term Investments	87,923		5
6	Prepaid Insurance	66,704		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	19,934		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,127,599	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,072,293		12
13	Land	252,793		13
14	Buildings, at Historical Cost	17,387,606		14
15	Leasehold Improvements, at Historical Cost	397,727		15
16	Equipment, at Historical Cost	4,715,884		16
17	Accumulated Depreciation (book methods)	(14,650,749)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Bond Issuance Costs</u>	285,678		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 14,461,232	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 15,588,831	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 901,289	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	288,918		29
30	Accrued Salaries Payable	405,299		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,653		31
32	Accrued Real Estate Taxes(Sch.IX-B)	195,933		32
33	Accrued Interest Payable	53,425		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,861,517	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,883,297		39
40	Mortgage Payable			40
41	Bonds Payable	5,460,324		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deferred Revenue from Advance Fees</u>	1,816,980		43
44	<u>Refundable Advance Fees</u>	1,806,165		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 12,966,766	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 14,828,283	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 760,548	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 15,588,831	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 455,039	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 455,039	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	305,509	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)	\$ 305,509	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 760,548	24 *

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

Facility Name & ID Number Friendship Manor

# 0024760

Report Period Beginning: 01/01/07

Ending: 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,920,729	1
2	Discounts and Allowances for all Levels	(66,007)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,854,722	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,845	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 9,845	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	50,176	13
14	Non-Patient Meals	354,714	14
15	Telephone, Television and Radio	69,853	15
16	Rental of Facility Space	79,703	16
17	Sale of Drugs	205,303	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	81,667	21
22	Laundry	133,390	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 974,806	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	95,421	24
25	Interest and Other Investment Income***	179,959	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 275,380	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Amortization of Advanced Fees/Nonresident Nursing</b>	2,707,725	28
28a	<b>Miscellaneous</b>	45,831	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,753,556	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,868,309	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,804,793	31
32	Health Care	3,230,930	32
33	General Administration	3,064,085	33
<b>B. Capital Expense</b>			
34	Ownership	1,407,887	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	17,016	35
36	Provider Participation Fee	38,089	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,562,800	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	305,509	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 305,509	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

# 0024760

Report Period Beginning:

01/01/07

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	1,347	1,884	\$ 60,464	\$ 32.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,529	7,565	155,157	20.51	3
4	Licensed Practical Nurses	27,445	30,597	536,867	17.55	4
5	CNAs & Orderlies	94,737	107,299	1,142,338	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,217	6,080	74,958	12.33	8
9	Activity Director	3,577	4,160	77,599	18.65	9
10	Activity Assistants	9,242	10,294	96,099	9.34	10
11	Social Service Workers	1,848	2,080	30,160	14.50	11
12	Dietician					12
13	Food Service Supervisor	2,948	3,395	78,324	23.07	13
14	Head Cook	3,994	4,355	57,003	13.09	14
15	Cook Helpers/Assistants	50,291	55,959	537,681	9.61	15
16	Dishwashers	12,561	13,169	105,059	7.98	16
17	Maintenance Workers	11,512	12,997	210,927	16.23	17
18	Housekeepers	27,498	31,453	302,687	9.62	18
19	Laundry	6,990	7,705	62,437	8.10	19
20	Administrator	1,968	2,136	210,512	98.55	20
21	Assistant Administrator	1,240	1,768	81,670	46.19	21
22	Other Administrative	21,895	25,501	603,898	23.68	22
23	Office Manager	1,392	1,731	71,114	41.08	23
24	Clerical	4,619	5,199	56,334	10.84	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	119	119	1,607	13.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	296,969	335,446	\$ 4,552,895 *	\$ 13.57	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			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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





**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. \$ 38,089  
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? 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. See Tab 24
- (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.

Friendship Manor  
Audit Report  
12/31/2007

Friendship Manor, Inc. changed their fiscal year end from June 30 to December 31. A financial statement audit was done through June 30, 2007, but the six month financial statement audit through December 31, 2007 has not yet been completed. Going forward, the audited financial statements will mirror the trial balance used to file the Long-term Care Cost Report. A copy of the June 30, 2007 Audit Report will accompany the file cost report, as well as a copy of the six month ending December 31, 2007 Audit Report when it is completed.