



Facility Name & ID Number Friendship Manor Health Center

# 0050161 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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 6/7/2017

	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	150	Skilled (SNF)	120	48,510	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	120	48,510	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,709	11,594	5,966	30,269	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,709	11,594	5,966	30,269	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.40%

D. How many bed reserve days during this year were paid by the Department? 2 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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 11/01/2008

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/2008 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 120 and days of care provided 2,712

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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	278,555	15,840	8,424	302,819		302,819		302,819		1
2	Food Purchase		182,031		182,031		182,031	(345)	181,686		2
3	Housekeeping	215,598	20,985		236,583		236,583		236,583		3
4	Laundry	72,475	13,033		85,508		85,508		85,508		4
5	Heat and Other Utilities			210,063	210,063		210,063	(13,932)	196,131		5
6	Maintenance	100,110	224	60,870	161,204		161,204		161,204		6
7	Other (specify):* <b>Infectious Waste</b>			5,817	5,817		5,817		5,817		7
8	<b>TOTAL General Services</b>	666,738	232,113	285,174	1,184,025		1,184,025	(14,277)	1,169,748		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,350	12,350		12,350		12,350		9
10	Nursing and Medical Records	1,806,524	81,219	12,155	1,899,898	14,878	1,914,776	(785)	1,913,991		10
10a	Therapy										10a
11	Activities	58,346	9,299	5,067	72,712		72,712	(2,707)	70,005		11
12	Social Services	98,157	56		98,213	(21,603)	76,610		76,610		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,963,027	90,574	29,572	2,083,173	(6,725)	2,076,448	(3,492)	2,072,956		16
	<b>C. General Administration</b>										
17	Administrative	78,737		120,000	198,737		198,737	(55,000)	143,737		17
18	Directors Fees										18
19	Professional Services			54,227	54,227	(14,878)	39,349		39,349		19
20	Dues, Fees, Subscriptions & Promotions			27,212	27,212	1,179	28,391	(12,460)	15,931		20
21	Clerical & General Office Expenses	97,784	12,007	46,439	156,230		156,230	(9,231)	146,999		21
22	Employee Benefits & Payroll Taxes			510,944	510,944		510,944	25,400	536,344		22
23	Inservice Training & Education			2,841	2,841		2,841		2,841		23
24	Travel and Seminar			2,358	2,358		2,358	(1,019)	1,339		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,588	64,588		64,588		64,588		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	176,521	12,007	828,609	1,017,137	(13,699)	1,003,438	(52,310)	951,128		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,806,286	334,694	1,143,355	4,284,335	(20,424)	4,263,911	(70,079)	4,193,832		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 &amp; ID Number

Friendship Manor Health Center

#0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	
	<b>D. Ownership</b>											
30	Depreciation			194,245	194,245		194,245	20,531	214,776			30
31	Amortization of Pre-Op. & Org.			36,933	36,933		36,933	(36,933)				31
32	Interest			239,423	239,423		239,423	(69,693)	169,730			32
33	Real Estate Taxes			75,314	75,314	(1,179)	74,135		74,135			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			577	577		577		577			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			546,492	546,492	(1,179)	545,313	(86,095)	459,218			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			523	523		523		523			38
39	Ancillary Service Centers		92,509	320,511	413,020		413,020		413,020			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,729	245,729		245,729		245,729			42
43	Other (specify):* <b>Marketing</b>					21,603	21,603	(21,603)				43
44	<b>TOTAL Special Cost Centers</b>		92,509	566,763	659,272	21,603	680,875	(21,603)	659,272			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,806,286	427,203	2,256,610	5,490,099		5,490,099	(177,777)	5,312,322			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$ (785)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,531	30		9
10	Interest and Other Investment Income	(9,951)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(345)	02		13
14	Non-Care Related Interest	(59,742)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,204)	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	(22,372)	21		24
25	Fund Raising, Advertising and Promotional	(12,460)	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	(80,349)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (170,677)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(7,100)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (7,100)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (177,777)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52	
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Friendship Manor Health Center

ID# 0050161

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Fees	\$ (4,155)	21	1
2	Flowers	(2,707)	11	2
3	Plant Cable	(13,932)	05	3
4	Amortization	(36,933)	31	4
5	Marketing Salary	(21,603)	43	5
6	Travel and Seminar	(1,019)	24	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>	(80,349)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor Health Center# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(345)	0	0	0	0	0	0	0	0	0	0	(345)	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	(13,932)	0	0	0	0	0	0	0	0	0	0	(13,932)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,277)</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>(14,277)</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	(785)	0	0	0	0	0	0	0	0	0	0	(785)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,707)	0	0	0	0	0	0	0	0	0	0	(2,707)	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>(3,492)</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>(3,492)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(55,000)	0	0	0	0	0	0	0	0	0	(55,000)	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	(12,460)	0	0	0	0	0	0	0	0	0	0	(12,460)	20
21	Clerical & General Office Expenses	(31,731)	22,500	0	0	0	0	0	0	0	0	0	(9,231)	21
22	Employee Benefits & Payroll Taxes	0	25,400	0	0	0	0	0	0	0	0	0	25,400	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,019)	0	0	0	0	0	0	0	0	0	0	(1,019)	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>(45,210)</b>	<b>(7,100)</b>	<b>0</b>	<b>(52,310)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(62,979)</b>	<b>(7,100)</b>	<b>0</b>	<b>(70,079)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor Health Center# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	20,531	0	0	0	0	0	0	0	0	0	0	20,531	30
31	Amortization of Pre-Op. & Org.	(36,933)	0	0	0	0	0	0	0	0	0	0	(36,933)	31
32	Interest	(69,693)	0	0	0	0	0	0	0	0	0	0	(69,693)	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>(86,095)</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>(86,095)</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):*	(21,603)	0	0	0	0	0	0	0	0	0	0	(21,603)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(21,603)</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>(21,603)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(170,677)</b>	<b>(7,100)</b>	<b>0</b>	<b>(177,777)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jay Frances	50					
Kimberly Smith	50					

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	17 Management Fees	\$ 120,000	Legacy Health Systems	100.00%	\$	(120,000)	1
2	V	17 Salaries		Legacy Health Systems		65,000	65,000	2
3	V	22 Taxes & Insurance		Legacy Health Systems		25,400	25,400	3
4	V	21 Telephone		Legacy Health Systems		10,000	10,000	4
5	V	21 Travel		Legacy Health Systems		11,000	11,000	5
6	V	21 Office Supplies		Legacy Health Systems		1,500	1,500	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 120,000			\$ 112,900	\$ * (7,100)	14

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



Facility Name & ID Number Friendship Manor Health Center # 0050161 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	\$		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 Health Center

# 0050161

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Friendship Manor Health Center

# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	Planters Bank		X	Mortgage Payable	\$27,706.16	11/1/08	\$ 2,187,000	\$ 3,578,547	10/30/22	4.5000	\$ 172,264	1								
2	Loan from Previous Owner		X	Mortgage Payable	\$7,407.84	11/1/08	667,250	79,094	11/1/18	6.0000	7,418	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				<b>\$35,114.00</b>		<b>\$ 2,854,250</b>	<b>\$ 3,657,641</b>			<b>\$ 179,682</b>	<b>9</b>								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(92)	10								
11	Interest Income	X									(9,858)	11								
12	N/P D. Frances	X		Buyout 33% of Ownership	\$8,249.45	1/1/16	1,250,000	1,173,407	1/1/36	5.0000	59,742	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>				<b>\$8,249.45</b>		<b>\$ 1,250,000</b>	<b>\$ 1,173,407</b>			<b>\$ 49,792</b>	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 4,104,250</b>	<b>\$ 4,831,048</b>			<b>\$ 229,474</b>	<b>15</b>								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2016 report.		\$	<b>77,705</b>	<b>1</b>
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.)		\$	<b>75,330</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,375)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>76,510</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>74,135</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	<b>81,818</b>	<b>8</b>	
	2013	<b>83,460</b>	<b>9</b>	
	2014	<b>83,236</b>	<b>10</b>	
	2015	<b>80,838</b>	<b>11</b>	
	2016	<b>75,330</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,539 B. General Construction Type: Exterior Brick Frame Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Empty lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 2008, \$211,500. Row 2: (blank). Row 3: TOTALS, \$211,500.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	120		2008	1964	\$ 3,788,500	\$	39	\$ 97,141	\$ 97,141	\$ 890,459
5										
6										
7										
8										
	Improvement Type**									
9	Various		2009		248,035		20	12,265	12,265	110,383
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 Health Center

# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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 Project-Wing 4	2010	\$ 57,268	\$	20	\$ 2,863	\$ 2,863	\$ 22,906	37
38	Sprinkler	2010	4,790		20	240	240	1,918	38
39	2 Water Heaters	2010	2,683		20	134	134	1,073	39
40	Holland Const/Aci Arch	2010	4,937		20	512	512	4,937	40
41	New Doors	2010	20,473		20	1,024	1,024	8,191	41
42	New Doors	2011	7,360		20	736	736	5,152	42
43	HVAC repairs	2011	4,414		20	441	441	3,088	43
44	Front Entrance Demolition, Millwork, Walls, Ceilings, Flooring	2011	34,675		20	1,734	1,734	12,137	44
45	New Roof	2011	5,899		20	590	590	4,130	45
46	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	2,233	46
47	Roof Repair	2011	3,100		20	155	155	1,085	47
48	Soffit & Fascia	2012	13,148		20	657	657	3,943	48
49	Two Bryant Rooftop A/Cs	2012	10,525		20	526	526	3,157	49
50	Sewer Line Replacement	2012	15,160		20	758	758	4,548	50
51	Kitchen Tile	2012	3,765		20	188	188	1,129	51
52	Soffit & Fascia	2012	4,183		20	209	209	1,254	52
53	Installation of 6" Seamless Guttering	2013	12,782		20	639	639	3,195	53
54	Installation of Walk in cooler	2013	8,460		20	423	423	2,115	54
55	Installation of Walk in Freezer	2013	9,130		20	457	457	2,285	55
56	Roof Replacement	2013	141,706		20	7,085	7,085	35,425	56
57	2 Carrier Ductless heat Pumps	2013	6,975		20	349	349	1,745	57
58	Concrete Resurfacing	2013	5,590		20	280	280	1,400	58
59	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	2,340	59
60	Dmt Gas Generator #54	2013	6,000		20	300	300	1,500	60
61	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	10,405	61
62	Rooftop AC unit	2014	5,355		10	536	536	1,926	62
63	Rebate of Installation of High Efficiency Lighting	2014	(18,266)		20	(913)	(913)	(3,652)	63
64	High Efficiency Lighting	2015	14,117		20	706	706	2,040	64
65	New Door for Snowman Freezer	2017	2,999		10				65
66	Fan on Boiler	2017	3,869		10	322	322	322	66
67									67
68									68
69	Financial Statement Depreciation			192,932			(192,932)		69
70	TOTAL (lines 4 thru 69)		\$ 4,484,989	\$ 192,932		\$ 133,225	\$ (59,707)	\$ 1,142,769	70

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

Facility Name & ID Number Friendship Manor Health Center

# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 802,386	\$	\$ 80,238	\$ 80,238	10	\$ 714,005	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 802,386	\$	\$ 80,238	\$ 80,238		\$ 714,005	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1998 HC Chevy Express Van	2015	\$ 6,564	\$ 1,313	\$ 1,313	\$	5	\$ 3,611	76
77										77
78										78
79										79
80	TOTALS			\$ 6,564	\$ 1,313	\$ 1,313	\$		\$ 3,611	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)	\$ 5,505,439	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 194,245	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 214,776	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,531	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,860,385	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<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. \_\_\_\_\_ /2018 \$ \_\_\_\_\_  
 13. \_\_\_\_\_ /2019 \$ \_\_\_\_\_  
 14. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

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: \$ 577 Description: See attached Schedule Copiers

(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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		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	39-03	hrs				\$ 125,598				\$ 125,598	1
2	Licensed Speech and Language Development Therapist	39-03	hrs				33,749				33,749	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-03/02	hrs				127,215	512			127,727	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-02	# of prescrpts					91,756			91,756	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____						33,949	241			34,190	12
13	Other (specify): _____	39-03/02										13
14	<b>TOTAL</b>				\$		\$ 320,511	\$ 92,509			\$ 413,020	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2017**

(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	\$ (18,992)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,902,740		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,089		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	337,466		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,263,303	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	212,336		13
14	Buildings, at Historical Cost	4,426,157		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	859,637		16
17	Accumulated Depreciation (book methods)	(2,260,037)		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):	212,338		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,450,431	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,713,734	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 487,493	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	470,724		29
30	Accrued Salaries Payable	129,110		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,510		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36		74,866		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,238,703	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,391,276		39
40	Mortgage Payable	3,657,641		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,048,917	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,287,620	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,573,886)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,713,734	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,140,864)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,140,864)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(405,022)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(28,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(433,022)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,573,886)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Friendship Manor Health Center

# 0050161

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,275,392	1
2	Discounts and Allowances for all Levels	(239,423)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,035,969	3
<b>B. Ancillary Revenue</b>			
4	Day Care	785	4
5	Other Care for Outpatients		5
6	Therapy	841,488	6
7	Oxygen	1,009	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 843,282	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	101,491	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,796	19
20	Radiology and X-Ray	2,261	20
21	Other Medical Services	30,326	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 195,874	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	9,951	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,951	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,085,076	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,184,025	31
32	Health Care	2,083,173	32
33	General Administration	1,017,136	33
<b>B. Capital Expense</b>			
34	Ownership	546,492	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	659,272	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,490,098	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(405,022)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (405,022)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,984,958	44
45	Private Pay - Net Inpatient Revenue	1,546,761	45
46	Medicare - Net Inpatient Revenue	329,718	46
47	Other-(specify) <u>Private Insurance</u>	85,547	47
48	Other-(specify) <u>Hospice</u>	88,985	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,035,969	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Incomplete 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 Health Center

# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	1,828	2,120	\$ 78,588	\$ 37.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,332	10,262	259,723	25.31	3
4	Licensed Practical Nurses	26,791	28,577	567,816	19.87	4
5	CNAs & Orderlies	70,024	73,183	869,194	11.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,776	6,123	58,346	9.53	10
11	Social Service Workers	2,773	3,341	76,554	22.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,436	22,139	278,555	12.58	15
16	Dishwashers					16
17	Maintenance Workers	4,657	5,496	100,110	18.22	17
18	Housekeepers	14,595	16,134	215,598	13.36	18
19	Laundry	6,146	6,766	72,475	10.71	19
20	Administrator	1,815	2,124	78,737	37.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,573	4,049	97,784	24.15	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	1,916	2,100	31,203	14.86	31
32	Other Health Care(specify)					32
33	Other(specify)	915	915	21,603	23.61	33
34	TOTAL (lines 1 - 33)	170,577	183,329	\$ 2,806,286 *	\$ 15.31	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	135	\$ 6,322	01-03	35
36	Medical Director	192	12,350	09-03	36
37	Medical Records Consultant	16	1,000	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,000	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	3,814	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	431	\$ 26,486		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	84	1,984	10-03	52
53	TOTAL (lines 50 - 52)	84	\$ 1,984		53

**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	
Laura Northway	Adminstrator	0	\$ 41,237	Workers' Compensation Insurance	\$ 181,098	IDPH License Fee	\$	
Heather Stitch	Adminstrator		37,500	Unemployment Compensation Insurance		Advertising: Employee Recruitment	9,514	
				FICA Taxes	235,930	Health Care Worker Background Check (Indicate # of checks performed 73 )	841	
				Employee Health Insurance	110,291	Patient Background Checks	86 1,210	
				Employee Meals		Dues & Subscriptions	800	
				Illinois Municipal Retirement Fund (IMRF)*		License & Fees	1,837	
				Employee Expense	9,025	Professional Fees	300	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,737					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 536,344	Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Accelerated Medical Billing	Billing Consulting		\$ 1,053			\$	Out-of-State Travel	\$
Hargis & Associates	Accounting		4,250					
Calhoun & Company	Accounting		1,510				In-State Travel	
Steber Training	Training Services		713					
Paycor	Payroll Processing		12,211				Seminar Expense	1,339
Pointclickcare	Computer Services		19,682					
Casamba	Computer Services		765					
Microsoft	Computer Services		466				Entertainment Expense	( )
Safe Mode	Computer Services		4,508				(agree to Sch. V, line 24, col. 8)	
Mckesson Medical	Computer Services		4,680					
Pitney Bowes	Postage		507					
Supplemental Page	Computer Services		3,882					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 54,227	TOTAL		\$	TOTAL	\$ 1,339

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Friendship Manor Health Center

# 0050161

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 120
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,496 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 245,729  
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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees