

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0051748</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Friendship House of Centralia</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/16/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1000 Martin Luther King</u> <u>Centralia</u> <u>62801</u>																									
Number City Zip Code																									
County: <u>Marion</u>																									
Telephone Number: <u>(618) 5323642</u> Fax # <u>(618) 533-3739</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Daren Douston</u></td></tr><tr><td>(Title) <u>Member/CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Matthew Larson</u> <u>Director of Reimbursement</u></td></tr><tr><td>(Firm Name & Address) <u>Five Rivers Management, LLC</u> <u>10945 State Bridge Rd. Ste 401-470 Alpharetta, GA 30022</u></td></tr><tr><td>(Telephone) <u>(678) 381-2820</u> Fax # <u>(678) 381-2821</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Daren Douston</u>	(Title) <u>Member/CFO</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Matthew Larson</u> <u>Director of Reimbursement</u>	(Firm Name & Address) <u>Five Rivers Management, LLC</u> <u>10945 State Bridge Rd. Ste 401-470 Alpharetta, GA 30022</u>	(Telephone) <u>(678) 381-2820</u> Fax # <u>(678) 381-2821</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												
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Date of Initial License for Current Owners: <u>2/1/2012</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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In the event there are further questions about this report, please contact:																									
Name: <u>Matthew Larson</u> Telephone Number: <u>(678) 381-2820</u>																									
Email Address: _____																									

Facility Name & ID Number Friendship House of Centralia# 0051748 Report Period Beginning: 1/16/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>19</u>	Skilled (SNF)	<u>19</u>	<u>6,669</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>75</u>	Intermediate (ICF)	<u>75</u>	<u>26,325</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>94</u>	TOTALS	<u>94</u>	<u>32,994</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>2,543</u>	<u>2,543</u>	8
9	SNF/PED					9
10	ICF	<u>15,333</u>	<u>803</u>	<u>411</u>	<u>16,547</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,333</u>	<u>803</u>	<u>2,954</u>	<u>19,090</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 57.86%

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

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

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

YES ☐NO ☒

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

Date started 1/16/2012

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

YES ☒Date 1/16/2012NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 19 and days of care provided 2,543Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	107,315	17,128	6,758	131,201		131,201		131,201		1
2	Food Purchase		122,864		122,864		122,864		122,864		2
3	Housekeeping	48,488	7,639	4,097	60,224		60,224		60,224		3
4	Laundry	36,609	3,865	1,191	41,665		41,665		41,665		4
5	Heat and Other Utilities			88,442	88,442		88,442		88,442		5
6	Maintenance	27,189	11,656	40,277	79,122		79,122		79,122		6
7	Other (specify):*			11,459	11,459		11,459		11,459		7
8	TOTAL General Services	219,601	163,152	152,224	534,977		534,977		534,977		8
	B. Health Care and Programs										
9	Medical Director			11,526	11,526		11,526		11,526		9
10	Nursing and Medical Records	972,741	42,529	11,958	1,027,228	7,849	1,035,077		1,035,077		10
10a	Therapy	4,025	84	321,280	325,389		325,389		325,389		10a
11	Activities	33,560	1,342	2,455	37,357		37,357		37,357		11
12	Social Services	29,251	129	1,962	31,342		31,342		31,342		12
13	CNA Training										13
14	Program Transportation							(12,593)	(12,593)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,039,577	44,084	349,181	1,432,842	7,849	1,440,691	(12,593)	1,428,098		16
	C. General Administration										
17	Administrative	37,200			37,200	2,756	39,956		39,956		17
18	Directors Fees										18
19	Professional Services			168,550	168,550		168,550	(107,393)	61,157		19
20	Dues, Fees, Subscriptions & Promotions			6,457	6,457		6,457	(63)	6,394		20
21	Clerical & General Office Expenses	40,943	36,987	20,589	98,519	(2,756)	95,763	6,483	102,246		21
22	Employee Benefits & Payroll Taxes			235,341	235,341		235,341	57,521	292,862		22
23	Inservice Training & Education			25	25		25	6	31		23
24	Travel and Seminar			1,341	1,341		1,341	328	1,669		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,025	56,025		56,025	136,881	192,906		26
27	Other (specify):*			8,453	8,453		8,453	(11,108)	(2,655)		27
28	TOTAL General Administration	78,143	36,987	496,781	611,911		611,911	82,656	694,567		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,337,321	244,223	998,186	2,579,730	7,849	2,587,579	70,063	2,657,642		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,010	4,010		4,010	309	4,319			30
31	Amortization of Pre-Op. & Org.			12,176	12,176		12,176	939	13,115			31
32	Interest			39,014	39,014		39,014	2,705	41,719			32
33	Real Estate Taxes			74,306	74,306		74,306	5,732	80,038			33
34	Rent-Facility & Grounds			104,865	104,865		104,865	8,089	112,954			34
35	Rent-Equipment & Vehicles			13,324	13,324	(7,849)	5,475	1,028	6,503			35
36	Other (specify):*											36
37	TOTAL Ownership			247,695	247,695	(7,849)	239,846	18,802	258,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		1,470	12,663	14,133		14,133	(70)	14,063			38
39	Ancillary Service Centers		105,084	105	105,189		105,189	1,782	106,971			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			145,706	145,706		145,706		145,706			42
43	Other (specify):*			4,415	4,415		4,415		4,415			43
44	TOTAL Special Cost Centers		106,554	162,889	269,443		269,443	1,712	271,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,337,321	350,777	1,408,770	3,096,868		3,096,868	90,577	3,187,445			45

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

		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	23	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(304)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(105)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,520)	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	(8,000)	27		24
25	Fund Raising, Advertising and Promotional	(1,130)	20		25
	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	(14,394)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,430)		\$	30

BHF USE ONLY							
48		49		50		51	52

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 Amount	2 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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (27,430)		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 Yes	2 No	3 Amount	4 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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0051748
Report Period Beginning: 1/16/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non Medical Transportation	\$ (12,593)	14	1
2	Chamber of Commerce Dues	(400)	20	2
3	Subscriptions	(36)	20	3
4	Permit	(75)	20	4
5	Vendor Late Fees	(2,655)	27	5
6	Prior Year Expenses	(348)	27	6
7	Medical Transportation	(70)	38	7
8	Prior Year Expense-Ancillary	1,782	39	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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33				33
34				34
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,394)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship House of Centralia

0051748

Report Period Beginning:

1/16/2012

Ending:

12/31/2012

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(12,593)	0	0	0	0	0	0	0	0	0	0	(12,593)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(12,593)	0	0	0	0	0	0	0	0	0	0	(12,593)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(119,401)	12,008	0	0	0	0	0	0	0	0	(107,393)	19
20	Fees, Subscriptions & Promotions	(1,641)	1,578	0	0	0	0	0	0	0	0	0	(63)	20
21	Clerical & General Office Expenses	(3,520)	10,003	0	0	0	0	0	0	0	0	0	6,483	21
22	Employee Benefits & Payroll Taxes	23	57,498	0	0	0	0	0	0	0	0	0	57,521	22
23	Inservice Training & Education	0	6	0	0	0	0	0	0	0	0	0	6	23
24	Travel and Seminar	0	328	0	0	0	0	0	0	0	0	0	328	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	136,881	0	0	0	0	0	0	0	0	0	136,881	26
27	Other (specify):*	(11,108)	0	0	0	0	0	0	0	0	0	0	(11,108)	27
28	TOTAL General Administration	(16,245)	86,893	12,008	0	0	0	0	0	0	0	0	82,656	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,838)	86,893	12,008	0	0	0	0	0	0	0	0	70,063	29

Summary B

12/31/2012

[illegible]

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
<u>Daren Douston</u>	<u>50%</u>	<u>Fireside House of Centralia</u>	<u>Centralia</u>	<u>Five Rivers Managem</u>	<u>Alpharetta</u>	<u>LTC Mgt/Acct</u>
<u>Kerry Gibson</u>	<u>50%</u>	<u>Great Bend Health & Rehab Center</u>	<u>Great Bend</u>	<u>Woodland-LTC, LLC</u>	<u>Shepherd</u>	<u>LTC Operator</u>
				<u>Rosewood-LTC, LLC</u>	<u>Converse</u>	<u>LTC Operator</u>

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	<u>Management Fees</u>	\$ <u>86,401</u>	<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	\$	\$ <u>(86,401)</u>	1
2	V	19	<u>Accounting Fees</u>	<u>33,000</u>	<u>Five Rivers Management, LLC</u>	<u>100.00%</u>		<u>(33,000)</u>	2
3	V	20	<u>Dues, Fees, Subs and Promos</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>1,578</u>	<u>1,578</u>	3
4	V	21	<u>Clerical & General Office Exp</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>10,003</u>	<u>10,003</u>	4
5	V	22	<u>Employee Benefits & Taxes</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>57,498</u>	<u>57,498</u>	5
6	V	23	<u>Training & education</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>6</u>	<u>6</u>	6
7	V	24	<u>Travel & Seminars</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>328</u>	<u>328</u>	7
8	V	26	<u>Liability Insurance</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>136,881</u>	<u>136,881</u>	8
9	V	30	<u>Depreciation</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>309</u>	<u>309</u>	9
10	V	31	<u>Amortization</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>939</u>	<u>939</u>	10
11	V	32	<u>Non Related interst</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>3,009</u>	<u>3,009</u>	11
12	V	33	<u>Real Estate Taxes</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>5,732</u>	<u>5,732</u>	12
13	V	34	<u>Building Lease</u>		<u>Five Rivers Management, LLC</u>	<u>100.00%</u>	<u>8,089</u>	<u>8,089</u>	13
14	Total			\$ <u>119,401</u>			\$ <u>224,372</u>	\$ * <u>104,971</u>	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Non Related Professional Svc	\$	Five Rivers Management, LLC	100.00%	\$ 12,008	\$ 12,008	15
16	V	35	Rental Equipment & Vehicles		Five Rivers Management, LLC	100.00%	1,028	1,028	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 13,036	\$ * 13,036	39

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

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								TOTAL	\$		13

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

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

Facility Name & ID Number Friendship House of Centralia # 0051748 Report Period Beginning: 1/16/2012 Ending: 2/31/2012

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 Five Rivers Management, LLC.
Street Address 10945 State Bridge Road, Ste 401-470
City / State / Zip Code Alpharetta, GA 30022
Phone Number (404) 991-2430
Fax Number (404) 991-2431

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Management Fees	Total Expenses	23,512,170	9	\$ 1,719,353	\$ 1,097,523	2,985,263	\$ 218,301	1
2	32	Capital	Total Expenses	23,512,170	9	150,484		2,985,263	19,106	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					\$ 1,869,837	\$ 1,097,523		\$ 237,407	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1							\$		\$			\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Zeigler Health Care		X	AR Financing				149,860		8/20/12		15.0000	4,060	6
7	Gemino		X	AR Financing				Variable					33,379	7
8	Insurance		X	Prop, Auto, Liab, WC				Variable					1,575	8
9	TOTAL Facility Related						\$	149,860	\$			\$	39,014	9
	B. Non-Facility Related*													
10														10
11														11
12														12
13														13
14	TOTAL Non-Facility Related						\$		\$			\$		14
15	TOTALS (line 9+line14)						\$	149,860	\$			\$	39,014	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.								
1. Real Estate Tax accrual used on 2011 report.	\$							1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$							2	
3. Under or (over) accrual (line 2 minus line 1).	\$							3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$						70,400	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$							5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$							6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$						70,400	7	
Real Estate Tax History:									
Real Estate Tax Bill for Calendar Year:	2007								
	2008								
	2009								
	2010								
	2011					76,769			

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Friendship House of Centralia

COUNTY
Marion

FACILITY IDPH LICENSE NUMBER
0051748

CONTACT PERSON REGARDING THIS REPORT
Daren Douston

TELEPHONE
(678) 381-2802
FAX #:
(678) 381-2803

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	14-17-0000-059	W1/2 W 6 A SW NE NW Tract 1&2	\$ 76,768.94	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 76,768.94	\$

B.
Real Estate Tax Cost Allocations

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

If YES, attach an explanation and 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

- A.

Square Feet:

23,100

B. General Construction Type:

Exterior

Brick & Block

Frame

Masonry

Number of Stories

1
- C.

Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

- F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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				\$	1
2					2
3	TOTALS			\$	3

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Nurse Call Control Module			2012	1,608	188	5	188	0	188
10	Generator Upgrades			2012	1,225	143	5	143	0	143
11	Comdial DX-120 Key Telephone System			2012	2,659	488	5	488	0	488
12	2 - Friedrich 8K BTU Room H/C			2012	1,286	43	5	43	0	43
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,778	\$ 861		\$ 862	\$ 1	\$ 862	70

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	10,105	1,861	3,148	1,287		1,861	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 10,105	\$ 1,861	\$ 3,148	\$ 1,287		\$ 1,861	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,883	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,010	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,288	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,723	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: LTC of Friendship, Inc

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:		94	2/1/2012	\$ 104,865	10	5	3
4	Additions							4
5								5
6								6
7	TOTAL		94		\$ 104,865			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 2/1/2012
 Ending 1/31/22

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2013</u>	\$ <u>16,400</u>
13.	<u>/2014</u>	\$ <u>118,437</u>
14.	<u>/2015</u>	\$ <u>120,510</u>

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8						
	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	10A1	87	hrs	\$	2,276		\$	87	\$	2,276	1			
2	Licensed Speech and Language Development Therapist			hrs								2			
3	Licensed Recreational Therapist			hrs								3			
4	Licensed Physical Therapist	10A1	87	hrs		1,748			87		1,748	4			
5	Physician Care			visits								5			
6	Dental Care			visits								6			
7	Work Related Program			hrs								7			
8	Habilitation			hrs								8			
9	Pharmacy			# of prescrpts								9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10			
11	Academic Education			hrs								11			
12	Other (specify):											12			
13	Other (specify):											13			
14	TOTAL				\$	4,024		\$		\$		174	\$	4,024	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,214	\$	1
2	Cash-Patient Deposits	32,604		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	712,596		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,143		6
7	Other Prepaid Expenses	4,355		7
8	Accounts Receivable (owners or related parties)	177,422		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 947,334	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,833		15
16	Equipment, at Historical Cost	14,050		16
17	Accumulated Depreciation (book methods)	(2,722)		17
18	Deferred Charges	28,636		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 42,797	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 990,131	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 171,797	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,604		28
29	Short-Term Notes Payable	572,560		29
30	Accrued Salaries Payable	117,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,698		31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrues Audit Fee & Bed Taxes	87,230		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,074,730	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,074,730	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (84,599)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 990,131	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,619)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,619)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,310)	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) Adjustment to Equity	25,330	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (80,980)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (84,599)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Friendship House of Centralia# 0051748Report Period Beginning: 1/16/2012Ending: 12/31/2012

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	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,391,398	1
2	Discounts and Allowances for all Levels	447,846	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,839,244	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	140,706	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 140,706	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(23)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	513	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,590	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,862	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,862	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		156	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 156	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,990,558	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	534,977	31
32	Health Care	1,432,843	32
33	General Administration	611,911	33
	B. Capital Expense		
34	Ownership	247,695	34
	C. Ancillary Expense		
35	Special Cost Centers	123,736	35
36	Provider Participation Fee	145,706	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,096,868	40
41	Income before Income Taxes (line 30 minus line 40)**	(106,310)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (106,310)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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.

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	3,718	4,193	\$ 125,812	\$ 30.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,668	6,168	133,005	21.56	3
4	Licensed Practical Nurses	13,828	15,290	286,943	18.77	4
5	CNAs & Orderlies	35,291	38,911	410,893	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,768	2,985	33,560	11.24	10
11	Social Service Workers	1,872	2,037	29,251	14.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,375	11,279	107,315	9.51	15
16	Dishwashers					16
17	Maintenance Workers	1,607	1,727	27,189	15.74	17
18	Housekeepers	5,044	5,512	48,488	8.80	18
19	Laundry	3,761	4,247	36,609	8.62	19
20	Administrator	1,548	1,662	39,956	24.04	20
21	Assistant Administrator					21
22	Other Administrative	2,322	2,624	38,187	14.55	22
23	Office Manager					23
24	Clerical					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	1,213	1,377	16,088	11.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	89,015	98,012	\$ 1,333,296 *	\$ 13.60	34

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	150	\$ 6,758	1-3	35
36	Medical Director		11,526	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	22	2,808	10-3	38
39	Pharmacist Consultant		1,888	39.3	39
40	Physical Therapy Consultant		148,067	10A-3	40
41	Occupational Therapy Consultant		151,205	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		22,008	10A-3	43
44	Activity Consultant		2,455	11-3	44
45	Social Service Consultant		1,962	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	\$ 348,677		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Friendship House of Centralia

0051748

Report Period Beginning:

1/16/2012

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Ending:

12/31/2012

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	
Mary Scharlemann	Administrator	0	\$ 37,790	Workers' Compensation Insurance	\$ 62,969	IDPH License Fee	\$ 237	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	237	
				FICA Taxes	144,263	Health Care Worker Background Check	4,342	
				Employee Health Insurance	22,567	(Indicate # of checks performed 120)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues	400	
				Employee Appreciation	1,654	Subscriptions	36	
						Permits	75	
TOTAL (agree to Schedule V, line 17, col. 1)				Dental Insurance	107	Promotional Advertising	1,130	
(List each licensed administrator separately.)			\$ 37,790	Life Insurance	3,779			
B. Administrative - Other						Less: Public Relations Expense	(511)	
Description			Amount			Non-allowable advertising	(1,130)	
			\$			Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 235,340	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,816	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
CT Corp	Register Agent		\$ 964					
Five Rivers Management	Accounting Fees		33,000					
AltaCare Corp	Accounting Fees		1,576					
Proliant	Payroll Processing		8,586				In-State Travel	
Gemino	Financing Service Fees		1,903					1,311
McNair, McLemore, Middlebrook	Legal Fees		295					
Gemino	Legal Fees		397					
Gemino	Auditing Fees		8,179				Seminar Expense	
Five Rivers Management	Management Fees		86,401				Seminar	30
AltaCare Corp	Management Fees		6,118					
Gemino	Lockbox Mgt Fees		17,989					
McNair, McLemore, Middlebrook	Auditing Fees		3,141				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 168,550				TOTAL	\$ 1,341

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?
If YES, give association name and amount.

No

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$ 8,920 Line 10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 49,490

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
\$ 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?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

c.

What percent of all travel expense relates to transportation of nurses and patients?

0

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

X

(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?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A