

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0050161</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>Friendship Manor Health Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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>485 S Friendship Dr</u> <u>Nashville</u> <u>62263</u> Number City Zip Code																																		
County: <u>Washington</u>																																		
Telephone Number: <u>(618) 327-3041</u> Fax # <u>(618) 327-4001</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>11/1/08</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Rhonda Houchens, Director of Operations</u></td></tr><tr><td>(Firm Name & Address) <u>Hargis & Associates, LLC</u> <u>PO Box 263 Russellville, KY 42276</u></td></tr><tr><td>(Telephone) <u>(270) 726-4033</u> Fax # <u>(270) 726-8069</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Rhonda Houchens, Director of Operations</u>	(Firm Name & Address) <u>Hargis & Associates, LLC</u> <u>PO Box 263 Russellville, KY 42276</u>	(Telephone) <u>(270) 726-4033</u> Fax # <u>(270) 726-8069</u>																					
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Type of Ownership:																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☒</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☐</td><td>Corporation</td></tr><tr><td>☐</td><td>"Sub-S" Corp.</td></tr><tr><td>☒</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☒	PROPRIETARY	☐	Individual	☐	Partnership	☐	Corporation	☐	"Sub-S" Corp.	☒	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
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In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE																																
Name: <u>Rhonda Houchens</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																
Telephone Number: <u>(270) 726-4033</u>		201 S. Grand Avenue East																																
Email Address: _____		Springfield, IL 62763-0001																																
		Phone # (217) 782-1630																																

Facility Name & ID Number Friendship Manor Health Care

0050161 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,646</u>	<u>12,427</u>	<u>4,249</u>	<u>32,322</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,646</u>	<u>12,427</u>	<u>4,249</u>	<u>32,322</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.59%

D. How many bed reserve days during this year were paid by the Department? 11 (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 11/1/08 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 3,341

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	268,713	1,888	7,990	278,591	1,707	280,298		280,298			1
2	Food Purchase		191,803		191,803	18,066	209,869	(365)	209,504			2
3	Housekeeping	195,024	2,882		197,906	21,200	219,106		219,106			3
4	Laundry	65,401	8,625		74,026	2,409	76,435		76,435			4
5	Heat and Other Utilities			181,941	181,941		181,941	(16,027)	165,914			5
6	Maintenance	81,991		54,195	136,186	7,753	143,939		143,939			6
7	Other (specify):* Infectious Waste			749	749	7,402	8,151		8,151			7
8	TOTAL General Services	611,129	205,198	244,875	1,061,202	58,537	1,119,739	(16,392)	1,103,347			8
	B. Health Care and Programs											
9	Medical Director			11,400	11,400		11,400		11,400			9
10	Nursing and Medical Records	1,730,475	186,910	14,024	1,931,409	(45,388)	1,886,021	1,083	1,887,104			10
10a	Therapy											10a
11	Activities	52,367	3,694	2,039	58,100		58,100	(793)	57,307			11
12	Social Services	56,161			56,161		56,161		56,161			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,839,003	190,604	27,463	2,057,070	(45,388)	2,011,682	290	2,011,972			16
	C. General Administration											
17	Administrative	114,249		120,000	234,249		234,249	(60,000)	174,249			17
18	Directors Fees											18
19	Professional Services			92,109	92,109	(15,256)	76,853	(16,672)	60,181			19
20	Dues, Fees, Subscriptions & Promotions			22,144	22,144		22,144	(12,664)	9,480			20
21	Clerical & General Office Expenses	103,953	14,380	294,987	413,320	509	413,829	(259,278)	154,551			21
22	Employee Benefits & Payroll Taxes			278,287	278,287		278,287	24,400	302,687			22
23	Inservice Training & Education											23
24	Travel and Seminar					697	697		697			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,454	110,454		110,454	(3,012)	107,442			26
27	Other (specify):*											27
28	TOTAL General Administration	218,202	14,380	917,981	1,150,563	(14,050)	1,136,513	(327,226)	809,287			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,668,334	410,182	1,190,319	4,268,835	(901)	4,267,934	(343,328)	3,924,606			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			114,179	114,179		114,179	15,649	129,828			30
31	Amortization of Pre-Op. & Org.			36,933	36,933		36,933	(36,933)				31
32	Interest			181,727	181,727		181,727	(71,234)	110,493			32
33	Real Estate Taxes			76,844	76,844		76,844	(10,488)	66,356			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			409,683	409,683		409,683	(103,006)	306,677			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,446	2,446		2,446		2,446			38
39	Ancillary Service Centers		83,312	431,865	515,177	901	516,078		516,078			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			238,609	238,609		238,609		238,609			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		83,312	672,920	756,232	901	757,133		757,133			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,668,334	493,494	2,272,922	5,434,750		5,434,750	(446,334)	4,988,416			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,649	30		9
10	Interest and Other Investment Income	(11,187)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(365)	02		13
14	Non-Care Related Interest	(39,973)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,672)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(274,900)	21		24
25	Fund Raising, Advertising and Promotional	(3,622)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,042)	20		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(98,122)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (438,234)		\$	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)	(8,100)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (8,100)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (446,334)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (4,620)	21	1
2	Flowers	(793)	11	2
3	Plant Cable	(16,027)	5	3
4	Amortization	(36,933)	31	4
5	Interest Expense (Closed Wing)	(20,074)	32	5
6	Property Insurance (Closed Wing)	(3,012)	26	6
7	Real Estate Taxes (Closed Wing)	(10,488)	33	7
8	Fines & Penalties	(2,258)	21	8
9	ADC Revenue	(3,917)	10	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(98,122)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor Health Care# 0050161

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	(365)	0	0	0	0	0	0	0	0	0	0	(365)	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	(16,027)	0	0	0	0	0	0	0	0	0	0	(16,027)	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	(16,392)	0	0	0	0	0	0	0	0	0	0	(16,392)	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	(3,917)	5,000	0	0	0	0	0	0	0	0	0	1,083	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(793)	0	0	0	0	0	0	0	0	0	0	(793)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,710)	5,000	0	0	0	0	0	0	0	0	0	290	16
	C. General Administration													
17	Administrative	0	(60,000)	0	0	0	0	0	0	0	0	0	(60,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,672)	0	0	0	0	0	0	0	0	0	0	(16,672)	19
20	Fees, Subscriptions & Promotions	(12,664)	0	0	0	0	0	0	0	0	0	0	(12,664)	20
21	Clerical & General Office Expenses	(281,778)	22,500	0	0	0	0	0	0	0	0	0	(259,278)	21
22	Employee Benefits & Payroll Taxes	0	24,400	0	0	0	0	0	0	0	0	0	24,400	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(3,012)	0	0	0	0	0	0	0	0	0	0	(3,012)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(314,126)	(13,100)	0	0	0	0	0	0	0	0	0	(327,226)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(335,228)	(8,100)	0	0	0	0	0	0	0	0	0	(343,328)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	15,649	0	0	0	0	0	0	0	0	0	0	15,649	30
31	Amortization of Pre-Op. & Org.	(36,933)	0	0	0	0	0	0	0	0	0	0	(36,933)	31
32	Interest	(71,234)	0	0	0	0	0	0	0	0	0	0	(71,234)	32
33	Real Estate Taxes	(10,488)	0	0	0	0	0	0	0	0	0	0	(10,488)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(103,006)	0	0	0	0	0	0	0	0	0	0	(103,006)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(438,234)	(8,100)	0	0	0	0	0	0	0	0	0	(446,334)	45

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	35.7					
Kimberly Smith	35.7					
Danny Frances	28.6					

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	\$ 120,000	Legacy Health Systems	100.00%	\$	\$(120,000)	1
2	V	17	Salaries		Legacy Health Systems		60,000	60,000	2
3	V	22	Taxes & Insurance		Legacy Health Systems		24,400	24,400	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	10	Nurse Consulting		Legacy Health Systems		5,000	5,000	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 120,000			\$ 111,900	\$ * (8,100)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Friendship Manor Health Care # 0050161 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Manor Health Care # 0050161 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Planters Bank		X	Mortgage Payable	\$27,706.16	11/1/08	\$ 2,187,000	\$ 2,991,747	10/30/22	4.5000	\$ 121,680	1	
2	Falcon Leasing		X	Finance Van Purchased	\$608.88	8/16/19	28,988	18,837	9/30/24	9.5000		2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$28,315.04		\$ 2,215,988	\$ 3,010,584			\$ 121,680	9	
	B. Non-Facility Related*												
10	Interest Income	X									(11,187)	10	
11	Planters Bank		X	Closed Wing Addition							20,074	11	
12	N/P D. Frances	X		Buyout 33% of Ownership	\$6,134.02	1/1/16	1,250,000		9/1/2048	5.0000	39,973	12	
13												13	
14	TOTAL Non-Facility Related				\$6,134.02		\$ 1,250,000				\$ 48,860	14	
15	TOTALS (line 9+line14)						\$ 3,465,988	\$ 3,010,584			\$ 170,540	15	

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 2019 report.			\$	76,510	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.)			\$	76,844	2
3. Under or (over) accrual (line 2 minus line 1).			\$	334	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	76,510	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.			\$	76,844	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	80,838	8	
		2016	75,330	9	
		2017	77,470	10	
		2018	76,510	11	
		2019	76,844	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor Health Care COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0050161

CONTACT PERSON REGARDING THIS REPORT Rhonda Houchens

TELEPHONE (270) 726-4033 FAX #: (270) 726-8069

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>10-12-23-251-007</u>	<u>Long Term Care Property</u>	\$ <u>1,062.74</u>	\$ <u>1,062.74</u>
2. <u>10-12-23-251-008</u>	<u>Long Term Care Property</u>	\$ <u>74,064.78</u>	\$ <u>63,576.78</u>
3. <u>10-12-23-256-003</u>	<u>Long Term Care Property</u>	\$ <u>196.12</u>	\$ <u>196.12</u>
4. <u>10-12-23-276-005</u>	<u>Long Term Care Property</u>	\$ <u>375.88</u>	\$ <u>375.88</u>
5. <u>10-12-23-279-005</u>	<u>Long Term Care Property</u>	\$ <u>1,143.98</u>	\$ <u>1,143.98</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>76,843.50</u></u>	\$ <u><u>66,355.50</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 54,960

B. General Construction Type: Exterior Brick Frame Number of Stories

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	Facility		2008	\$ 211,500	1
2					2
3	TOTALS			\$ 211,500	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	\$ 1,181,882	4
5			2008	1964	(536,498)			(13,794)	(13,794)	(41,382)	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2009		248,035		20	12,265	12,265	147,178	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Friendship Manor Health Care

0050161

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	\$ 31,495	37
38	Sprinkler	2010	4,790		20	240	240	2,638	38
39	2 Water Heaters	2010	2,683		20	134	134	1,475	39
40	Holland Const/Aci Arch	2010	4,937		20			4,937	40
41	New Doors	2010	20,473		20	1,024	1,024	11,263	41
42	New Doors	2011	7,360		10	736	736	7,360	42
43	HVAC repairs	2011	4,414		10	441	441	4,411	43
44	Front Entrance Demolition, Millwork, Walls, Ceilings, Flooring	2011	34,675		20	1,734	1,734	17,339	44
45	New Roof	2011	5,899		10	590	590	5,900	45
46	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	3,190	46
47	Roof Repair	2011	3,100		20	155	155	1,550	47
48	Soffit & Fascia	2012	13,148		20	657	657	5,914	48
49	Two Bryant Rooftop A/Cs	2012	10,525		20	526	526	4,735	49
50	Sewer Line Replacement	2012	15,160		20	758	758	6,822	50
51	Kitchen Tile	2012	3,765		20	188	188	1,693	51
52	Soffitt & Fascia	2012	4,183		20	209	209	1,881	52
53	Installation of 6" Seamless Guttering	2013	12,782		20	639	639	5,112	53
54	Installation of Walk in Cooler	2013	8,460		20	423	423	3,384	54
55	Installation of Walk in freezer	2013	9,130		20	457	457	3,656	55
56	Roof Replacemnt	2013	141,706		20	7,085	7,085	56,680	56
57	2 Carrier Ductless heat pumps	2013	6,975		20	349	349	2,792	57
58	Concrete Resurfacing	2013	5,590		20	280	280	2,240	58
59	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	3,744	59
60	Dmt Gas Generator #54	2013	6,000		20	300	300	2,400	60
61	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	16,648	61
62	Rooftop AC Unit	2014	5,355		20	536	536	3,534	62
63	Rebate of Installation of High Efficiency Lighting	2014	(18,266)		20	(913)	(913)	(6,391)	63
64	High Efficiency Lighting	2015	14,117		20	706	706	4,158	64
65	New Door for Snowman Freezer	2017	2,999		10	300	300	900	65
66	Fan on Boiler	2017	3,869		10	387	387	1,483	66
67	Actuator/Valve for Boiler	2018	8,929		7	1,276	1,276	2,552	67
68	Roof, Gutters, and Downspouts	2020	52,493		20	1,532	1,532	1,532	68
69	Boiler Pressure Switch & Disconnect	2020	5,507		10	92	92	92	69
70	TOTAL (lines 4 thru 69)		\$ 4,015,420	\$		\$ 122,184	\$ 122,184	\$ 1,504,797	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 4,015,420	\$		\$ 122,184	\$ 122,184	\$ 1,504,797	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	Financial Statement Depreciation			106,535			(106,535)		33
34	TOTAL (lines 1 thru 33)		\$ 4,015,420	\$ 106,535		\$ 122,184	\$ 15,649	\$ 1,504,797	34

**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	\$806,391	\$477	\$477	\$	10	\$803,817	71
72	Current Year Purchases	13,180	705	705		10	705	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$819,571	\$1,182	\$1,182	\$		\$804,522	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	\$327	\$327	\$	5	\$6,564
77	Facility	Handicap Dodge Caravan	2019	30,673	6,135	6,135		5	8,180
78									78
79									79
80	TOTALS			\$37,237	\$6,462	\$6,462	\$		\$14,744

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	5,083,728
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	114,179
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	129,828
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	15,649
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,324,063

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	Building Closed Wing/2008	\$536,498	\$13,794	\$41,382
87				
88				
89				
90				
91	TOTALS	\$536,498	\$13,794	\$41,382

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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	TOTAL				\$			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
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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	39-03	hrs	\$		\$ 140,197	\$		\$ 140,197	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			108,781			108,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03-02	hrs			143,178	1,242		144,420	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				74,707		74,707	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	39-02/03				39,709	8,264		47,973	13
14	TOTAL			\$		\$ 431,865	\$ 84,213		\$ 516,078	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	\$ 456,882	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,466,904		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,320		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	285,445		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,210,551	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	193,712		13
14	Buildings, at Historical Cost	3,967,051		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	910,141		16
17	Accumulated Depreciation (book methods)	(2,667,658)		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):	536,498		22
23	Other(specify):	101,539		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,041,283	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,251,834	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 819,481	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	940,656		29
30	Accrued Salaries Payable	113,731		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
	Other Current Liabilities(specify):			
36		1,445,518		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,395,896	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,991,747		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Transfer</u>	246,228		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,237,975	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,633,871	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 617,963	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,251,834	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,345,901)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,345,901)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	904,665	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	(35,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Paid in Captial	1,094,199	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,963,864	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)	\$ 617,963	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Friendship Manor Health Care

0050161

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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	\$ 4,592,879	1
2	Discounts and Allowances for all Levels	159,857	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,752,736	3
	B. Ancillary Revenue		
4	Day Care	3,917	4
5	Other Care for Outpatients		5
6	Therapy	920,372	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 924,289	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,693	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,871	19
20	Radiology and X-Ray	3,158	20
21	Other Medical Services	12,977	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 227,699	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,187	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,187	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		423,504	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 423,504	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,339,415	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,061,202	31
32	Health Care	2,057,070	32
33	General Administration	1,150,563	33
	B. Capital Expense		
34	Ownership	409,683	34
	C. Ancillary Expense		
35	Special Cost Centers	517,623	35
36	Provider Participation Fee	238,609	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,434,750	40
41	Income before Income Taxes (line 30 minus line 40)**	904,665	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 904,665	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,063,648	44
45	Private Pay - Net Inpatient Revenue	1,871,155	45
46	Medicare - Net Inpatient Revenue	692,747	46
47	Other-(specify) <u>Private Insurance</u>	15,260	47
48	Other-(specify) <u>Hospice</u>	109,926	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,752,736	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.

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	1,821	2,125	\$ 92,522	\$ 43.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,325	10,182	278,099	27.31	3
4	Licensed Practical Nurses	16,712	17,944	447,341	24.93	4
5	CNAs & Orderlies	57,334	60,556	877,449	14.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,948	4,320	52,367	12.12	10
11	Social Service Workers	1,903	2,137	56,161	26.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,195	18,753	268,713	14.33	15
16	Dishwashers					16
17	Maintenance Workers	2,808	3,272	81,991	25.06	17
18	Housekeepers	11,821	13,510	195,024	14.44	18
19	Laundry	4,773	5,358	65,401	12.21	19
20	Administrator	1,872	2,092	114,249	54.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,576	4,094	103,953	25.39	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	1,840	2,109	35,064	16.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,928	146,452	\$ 2,668,334 *	\$ 18.22	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	97	\$ 6,787	01-03	35
36	Medical Director	192	11,400	09-03	36
37	Medical Records Consultant	5	350	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	126	9,057	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	32	2,040	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	452	\$ 29,634		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	40	\$ 2,668	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	168	6,518	10-03	52
53	TOTAL (lines 50 - 52)	208	\$ 9,186		53

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Friendship Manor Health Care

0050161

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Heather Stich	Administrator	0	\$ 114,249
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,249

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Safe Mode	Computer Services	\$ 2,826
Siteground Hosting	Computer Services	334
Microsoft	Computer Services	316
Adobe Acrobat	Computer Services	49
Calhoun & Company	Accounting Fees	1,285
Hargis & Associates	Accounting Fees	4,250
Fast Track Billing	Consulting Fees	3,275
David C Read, CPA, LNHA	Consulting Fees	1,150
Accelerated Medical Billing	Consulting Fees	(71)
Flynn, Guymon & Garavalia	Legal Fees	6,103
McMahon & Berger	Legal Fees	21,005
See attached		51,587
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 92,109

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 60,948
Unemployment Compensation Insurance	
FICA Taxes	112,398
Employee Health Insurance	114,902
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	14,439
TOTAL (agree to Schedule V, line 22, col.8)	\$ 302,687

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	3,569
Health Care Worker Background Check (Indicate # of checks performed 58)	394
Patient Background Checks 44	1,025
Dues & Subscriptions	265
Taxes & Licenses	2,471
Professional Fees	1,150
Emp Injury/Drug Screen	606
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,480

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	697
Seminar Expense	
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 697

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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. \$ 8,885 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. \$ 238,609
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees.