

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0024760

Facility Name: Friendship Manor

Address: 1209 21st Avenue Rock Island 61201

County: Rock Island

Telephone Number: (309) 786-9667 Fax # (309) 786-5611

HFS ID Number:

Date of Initial License for Current Owners: 6/29/1979

Type of Ownership:

x

VOLUNTARY,NON-PROFIT

x

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Robert Schlicht

Telephone Number: +1(414) 431-9335

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 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.

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Print Name and Title) Robert Schlicht Director

(Firm Name & Address) Wipfli Advisory LLC 10000 Innovation Drive, Suite 250, Milwaukee, WI 53226

(Telephone) +1(414) 431-9335 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406

Phone # (217) 782-1630

Facility Name & ID Number

Friendship Manor

0024760

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,526	1,299	2,825	8
9	SNF/PED									9
10	ICF	4,531	4,618	771		14,305		59	24,284	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,531	4,618	771		14,305	1,526	1,358	27,109	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

79.01%

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

None (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 6/29/1979

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

YES NO Date 6/29/1979

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

YES NO

If YES, enter certified beds.

number of certified beds 94

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL CASH* CASH*

Is your fiscal year identical to your tax year?

YES NO

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number **Friendship Manor** # **0024760** Report Period Beginning: **1/1/2025** Ending: **12/31/2025**
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	587,557	58,992	8,685	655,234		655,234		655,234			1
2	Food Purchase		410,180		410,180		410,180	(10,604)	399,576			2
3	Housekeeping	355,959	41,207	3,005	400,171		400,171	(612)	399,559			3
4	Laundry	39,821	12,217	222	52,260		52,260		52,260			4
5	Heat and Other Utilities			140,539	140,539		140,539	(20,683)	119,856			5
6	Maintenance	193,083	6,886	91,405	291,374		291,374	14,625	305,999			6
7	Other (specify):*											7
8	TOTAL General Services	1,176,420	529,482	243,856	1,949,758		1,949,758	(17,273)	1,932,485			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800		28,800		28,800			9
10	Nursing and Medical Records	3,948,961	142,950		4,091,911		4,091,911		4,091,911			10
10a	Therapy		1,835		1,835		1,835		1,835			10a
11	Activities	105,792	19,984	368	126,144		126,144		126,144			11
12	Social Services	71,516	256		71,772		71,772		71,772			12
13	CNA Training											13
14	Program Transportation			2,989	2,989		2,989		2,989			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,126,269	165,025	32,157	4,323,451		4,323,451		4,323,451			16
	C. General Administration											
17	Administrative	98,942			98,942		98,942		98,942			17
18	Directors Fees											18
19	Professional Services			207,018	207,018		207,018		207,018			19
20	Dues, Fees, Subscriptions & Promotions			5,008	5,008		5,008		5,008			20
21	Clerical & General Office Expenses	415,740	7,212	123,437	546,389		546,389	(132,281)	414,108			21
22	Employee Benefits & Payroll Taxes			2,095,847	2,095,847		2,095,847		2,095,847			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,597	5,597		5,597		5,597			24
25	Other Admin. Staff Transportation							(14)	(14)			25
26	Insurance-Prop.Liab.Malpractice			179,456	179,456		179,456		179,456			26
27	Other (specify):*											27
28	TOTAL General Administration	514,682	7,212	2,616,363	3,138,257		3,138,257	(132,295)	3,005,962			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,817,371	701,719	2,892,376	9,411,466		9,411,466	(149,568)	9,261,898			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			1,103,409	1,103,409		1,103,409	(891,112)	212,297			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			227,099	227,099		227,099	(227,099)				32
33	Real Estate Taxes			401,578	401,578		401,578		401,578			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,698	9,698		9,698		9,698			35
36	Other (specify):*			11,153	11,153		11,153		11,153			36
37	TOTAL Ownership			1,752,937	1,752,937		1,752,937	(1,118,211)	634,726			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	516,190	161,160	17,742	695,092		695,092		695,092			39
40	Barber and Beauty Shops			41,161	41,161		41,161		41,161			40
41	Coffee and Gift Shops			47,255	47,255		47,255	(47,255)				41
42	Provider Participation Fee			476,275	476,275		476,275		476,275			42
43	Other (specify):*	5,518,474	1,247,571	3,031,023	9,797,068		9,797,068	(9,855,867)	(58,799)			43
44	TOTAL Special Cost Centers	6,034,664	1,408,731	3,613,456	11,056,851		11,056,851	(9,903,122)	1,153,729			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,852,035	2,110,450	8,258,769	22,221,254		22,221,254	(11,170,901)	11,050,353			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	(7,097)	2		4
5	Telephone, TV & Radio in Resident Rooms	(20,683)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(891,112)	30		9
10	Interest and Other Investment Income	(227,099)	32		10
11	Discounts, Allowances, Rebates & Refunds	(461)	2		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)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,736)	21		18
19	Entertainment	(298)	21		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	(49,427)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,972,988)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (11,170,901)		\$	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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (11,170,901)		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			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ 0	20
2	Other Expenses Related to Lobbying Activities		2
3	Bistro Revenue	(3,046)	2
4	Maintenance Services	(2,059)	6
5	Country Store Revenue	(47,255)	41
6		0	0
7	Administration Miscellaneous Income	(4,611)	21
8	Telephone & Internet Revenue	(66,478)	21
9	Flowers and Gifts	(647)	21
10	Bank Charges	(855)	21
11	Investment Fees	(4,757)	21
12	Housekeeping Services	(612)	3
13	Cash Discount	(3,472)	21
14	Non-Reimbursable Salaries	(2,867,161)	43
15	Non-Reimbursable Supplies	(414,862)	43
16	Non-Reimbursable Other Expenses	(6,573,844)	43
17	Travel-Culinary	(14)	25
18	Capitalized R&M	(20,540)	6
19	Additional R& M	37,224	6
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
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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	(9,972,988)	

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[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
n/a						

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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			\$			\$	\$	15
16	V								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			\$			\$0	\$ *	39

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

STATE OF ILLINOIS

Ownership Listing-1

Friendship Manor

ID# 0024760

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management
Co. /Home Offi

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
1	Ann		Austin	Rock Island	IL			1
2	Ada		Christopher	Moline	IL			2
3	Ted		Rogalski	Aledo	IL			3
4	Jessey		Hullon	Moline	IL			4
5	Rev Damon		Colvin	Rock Island	IL			5
6	Thomas		Spitzfaden	Moline	IL			6
7	Molly		Shattuck	Moline	IL			7
8	Shen		Doyle	Rock Island	IL			8
9	Liz		Tallman	Rock Island	IL			9
10	Molly		Foley	Moline	IL			10
11	Jon		Loquist	Bettendorf	IL			11
12	Ted		Pappas Jr	Rock Island	IL			12
13	John		McEvoy, Jr	Rock Island	IL			13
14	Chris		Eisberg	Rock Island	IL			14
15	John		Thorson	Rock Island	IL			15
16								16
17								17
18								18
19								19
20								20
21								21
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73								73
74								74
75								75

VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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

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 # 0024760 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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

Facility Name & ID Number Friendship Manor # 0024760 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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	Blackhawk Bank & Trust		X	Interest Bonds 2012	\$56,825.56	12/28/2012	\$ 8,650,000	\$ 3,568,312	12/15/2032	3.9000	\$ 149,594	1	
2	Blackhawk Bank & Trust		X	Interest Bonds 2014	\$26,177.76	11/19/2014	4,000,000	2,558,778	5/15/2036	4.9000	129,921	2	
3	Blackhawk Bank & Trust		X	Interest Bonds 2023	\$64,479.19	10/01/2023	10,500,000	10,450,712	9/15/2050	5.5000	420,546	3	
4	American Bank & Trust		X	Interest- City of RI Loan	Interest	3/31/2014	250,000	250,000	1/2/2035	2.0000	5,000	4	
5	Blackhawk Bank & Trust		X	Interest Bank Note -Term Note	\$26,518.80	1/17/2023	3,929,395	3,726,654	1/15/2026	6.5000	244,657	5	
	Working Capital												
6	Blackhawk Bank & Trust		X	Revolving Line of Credit	Interest	1/15/2025	1,000,000		1/15/2026	7.2500	13,993	6	
7	Blackhawk Bank & Trust		X	Revolving Line of Credit	Interest	1/15/2024	1,000,000		1/15/2025	7.7500		7	
8	Blackhawk Bank & Trust		X	ERTC Bridge Loan	Interest	7/7/2025	1,000,000		1/15/2025	7.2500	2,113	8	
9	TOTAL Facility Related				\$174,001.31		\$ 30,329,395	\$ 20,554,455			\$ 965,824	9	
	B. Non-Facility Related*												
10	Interest Income		X								(293,900)	10	
11	Allocation to AL/IL		X								(671,924)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (965,824)	14	
15	TOTALS (line 9+line14)						\$ 30,329,395	\$ 20,554,455			\$ 0	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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	356,168	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.)				\$	364,304	2
3. Under or (over) accrual (line 2 minus line 1).				\$	8,136	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	393,442	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.				\$	401,578	7
Assessed Value from Real Estate Tax Bill:	2024		8			
Real Estate Tax Bill for Calendar Year:	2020	401,585	9			
	2021	293,515	10			
	2022	308,649	11			
	2023	318,272	12			
	2024	364,304	13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

- 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

32,336

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

2

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).

Independent & Assisted Living

Memory Care

Restricted / Unrestricted Development

Rental Property

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒

If YES, please indicate name of the facility,

IDPH license number of this related party and the date the present owners took over.

N/A

K. 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		1973	\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	94		1979	1979	\$ 1,861,259	\$	40	\$	\$	\$ 1,861,259	4
5			1985	1985	2,286,316		40	18,728	18,728	2,286,316	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		6,283		20			6,283	9
10	Various		1997		68,766		20			68,766	10
11	Various		1998		81,587		20			81,587	11
12	Various		1999		20,215		20			20,215	12
13	Various		2002		8,106		20			8,106	13
14	Various		2003		5,041		20			5,041	14
15	Various		2005		180,073		20			180,073	15
16	Various		2006		33,478		20	19	19	33,477	16
17	Various		2007		16,471		20	92	92	16,377	17
18	Various		2008		100,025		20	4,200	4,200	92,898	18
19	Various		2009		28,436		20	995	995	25,178	19
20	Various		2010		188,920		20	8,658	8,658	172,925	20
21	Various		2011		26,945		20	1,347	1,347	21,959	21
22	Various		2012		334,388		20	16,719	16,719	268,362	22
23	Various		2013		103,802		20	5,190	5,190	67,472	23
24	Various		2014		197,847		20	9,893	9,893	121,347	24
25	Various		2015		76,896		20	3,845	3,845	42,293	25
26	Various		2016		380,203		20	19,010	19,010	190,100	26
27	Various		2017		234,170		20	11,710	11,710	105,214	27
28	Various		2018		102,298		20	5,115	5,115	40,919	28
29	Various		2019		135,222		20	6,760	6,760	47,320	29
30											30
31											31
32											32
33											33
34											34
35	Financial Statement Depreciation					1,103,409			(1,103,409)		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

0024760

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	Loading Dock Driveway (52,030)	2020	\$ 7,669	\$	20	\$ 383	\$ 383	\$ 2,298	37
38	Mural On Maintenance Building (21,199)	2020	3,125		20	156	156	936	38
39	Silver Cross Wheelchair Patio Table Access	2020	2,600		20	130	130	780	39
40	Kitchen Fire Suppression System (3,907)	2020	576		20	29	29	174	40
41	Loading Dock (52,686)	2020	7,766		20	388	388	2,328	41
42	Control Panel In Sc Fire Alarm System	2020	4,315		20	216	216	1,296	42
43	Parking Lot Patching (37,950)	2021	11,851		20	593	593	2,965	43
44	Compressor Replacement (30,486)	2021	9,520		20	476	476	2,380	44
45	Control Valve (11,892)	2021	1,753		20	88	88	440	45
46	Health Center Room 101 Flooring	2021	2,948		20	147	147	735	46
47	Walk In Cooler (14,722)	2021	4,598		20	230	230	1,150	47
48	Two Boiler Room Hot Water Expansion Tanks (3,448)	2021	1,077		20	54	54	270	48
49	Parking Lot Seal Coating (84,350)	2022	26,342		20	1,317	1,317	5,268	49
50	4 Nursing Stations	2022	26,316		20	1,316	1,316	5,264	50
51	Board Room Fan Coil Unit (3,895)	2022	1,216		20	61	61	244	51
52	Kitchen Drain Line (19,750)	2022	6,168		20	308	308	1,232	52
53	Nc Secure Care To Door	2022	4,679		20	234	234	936	53
54	Silver Cross 911 Call Notification Lights	2022	2,714		20	136	136	544	54
55	Sound system for Chapel(19,385)	2022	6,054		20	303	303	1,212	55
56	Boiler Room Water Softener	2023	5,640		20	282	282	846	56
57	Health Center Room 104 Flooring	2023	3,410		20	170	170	510	57
58	Health Center Room 110 Flooring	2023	3,277		20	164	164	492	58
59	Health Center Room 111 Flooring	2023	3,277		20	164	164	492	59
60	Health Center Room 118 Flooring	2023	3,177		20	159	159	477	60
61	Health Center Room 265 Flooring	2023	3,035		20	152	152	456	61
62	Nurse Call System - Replace Master Station At Main Nurse Desk	2023	2,532		20	127	127	381	62
63	Storm Sewer Repair - Asphalt And Backfill	2023	3,020		20	151	151	453	63
64	Building Automation System Improvement	2024	2,358		20	118	118	236	64
65	Wireless Access Point UpgradeAll Blds	2024	50,124		20	2,506	2,506	5,012	65
66	Health Center Rm 100 Flooring	2024	3,277		20	164	164	328	66
67	Health Center Rm 106 Flooring	2024	3,277		20	164	164	328	67
68	Health Center Rm 119 Flooring	2024	3,277		20	164	164	328	68
69	Health Center Rm 121 Flooring	2024	3,277		20	164	164	328	69
70	TOTAL (lines 4 thru 69)		\$ 6,700,994	\$ 1,103,409		\$ 123,495	\$ (979,915)	\$ 5,804,605	70

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

****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	\$494,564	\$	\$48,249	\$48,249	10	\$371,589	71
72	Current Year Purchases	713,763		27,289	27,289	10	27,289	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,208,327	\$	\$75,538	\$75,538		\$398,878	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		Resident Bus - Reynolds Motor	2012	\$16,982	\$	\$	\$		\$16,982	76
77		Steel Plow for Pickup (6,154)	2015	2,135					2,135	77
78		2015 Ford truck (34,573)	2015	11,993					11,993	78
79		See attached		59,150		168	168		49,209	79
80	TOTALS			\$90,260	\$	\$168	\$168		\$80,319	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,980,630	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,103,409	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$212,296	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(891,113)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,297,949	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	Various Non Care	\$33,149,478	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$33,149,478	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Legacy B	\$809,687	92
93			93
94			94
95		\$809,687	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: \$22,894
- 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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	39-01	hrs	\$ 87,163		\$	\$		\$ 87,163	1
2	Licensed Speech and Language Development Therapist	39-01	hrs	85,030					85,030	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	hrs	343,997					343,997	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			\$ 516,190		\$	\$		\$ 516,190	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	\$ 630,438	\$	1
2	Cash-Patient Deposits	1,592		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,228,942		3
4	Supply Inventory (priced at)	112,242		4
5	Short-Term Investments	5,328,465		5
6	Prepaid Insurance	108,781		6
7	Other Prepaid Expenses	79,473		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,076		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,493,009	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,408,844		11
12	Long-Term Investments	854,878		12
13	Land	44,969,108		13
14	Buildings, at Historical Cost	2,006,812		14
15	Leasehold Improvements, at Historical Cost	9,281,197		15
16	Equipment, at Historical Cost	(33,810,071)		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,984,945		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,695,713	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 34,188,722	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,881,374	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	928,816		29
30	Accrued Salaries Payable	917,867		30
31	Accrued Taxes Payable (excluding real estate taxes)	58,763		31
32	Accrued Real Estate Taxes(Sch.IX-B)	475,000		32
33	Accrued Interest Payable	45,591		33
34	Deferred Compensation	808,152		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		215,311		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,330,874	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,897,129		39
40	Mortgage Payable			40
41	Bonds Payable	15,728,510		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Rental Deposits	3,200		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,628,839	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 24,959,713	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,229,009	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 34,188,722	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,284,624	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,284,624	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,250,110	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	375,976	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) realized/unrealized investment gains	148,258	15
16	Other (describe) net assets released from restrictions	(1,829,959)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,944,385	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)	\$ 9,229,009	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Friendship Manor

0024760

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 7,795,149	1
2	Discounts and Allowances for all Levels	(294,099)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,501,050	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	710,085	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 710,085	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,629,766	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	63,709	12
13	Barber and Beauty Care	50,905	13
14	Non-Patient Meals	793,631	14
15	Telephone, Television and Radio	66,478	15
16	Rental of Facility Space		16
17	Sale of Drugs	101,792	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,622	19
20	Radiology and X-Ray	3,581	20
21	Other Medical Services	28,288	21
22	Laundry	173,519	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,914,291	23
	D. Non-Operating Revenue		
24	Contributions	503,451	24
25	Interest and Other Investment Income***	962,423	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,465,874	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent & Assisted Living	10,002,694	28
28a	Other Income	1,877,371	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,880,065	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 25,471,365	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,949,758	31
32	Health Care	4,323,451	32
33	General Administration	3,079,459	33
	B. Capital Expense		
34	Ownership	1,752,937	34
	C. Ancillary Expense		
35	Special Cost Centers	10,639,375	35
36	Provider Participation Fee	476,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,221,255	40
41	Income before Income Taxes (line 30 minus line 40)**	3,250,110	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,250,110	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,044,830.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,064,892.00	45
46	MMAI-Medicaid is the Primary Payer	177,789.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	4,396,288.00	48
49	Medicare Part A	817,251.00	49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,501,050	56

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	1,746	2,028	\$ 104,429	\$ 51.48	1
2	Assistant Director of Nursing	2,151	2,486	118,197	47.54	2
3	Registered Nurses	14,726	15,391	694,637	45.13	3
4	Licensed Practical Nurses	30,142	31,404	1,180,668	37.60	4
5	CNAs & Orderlies	72,024	75,577	1,756,773	23.24	5
6	CNA Trainees			0		6
7	Licensed Therapist	11,233	12,417	516,190	41.57	7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	4,835	5,268	105,792	20.08	10
11	Social Service Workers	2,080	2,080	71,516	34.38	11
12	Dietician			0		12
13	Food Service Supervisor			0		13
14	Head Cook			0		14
15	Cook Helpers/Assistants	32,023	33,806	587,557	17.38	15
16	Dishwashers			0		16
17	Maintenance Workers	7,673	8,352	193,083	23.12	17
18	Housekeepers	19,374	21,138	355,959	16.84	18
19	Laundry	2,220	2,512	39,821	15.85	19
20	Administrator	1,363	1,560	98,842	63.36	20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical	14,894	16,803	351,861	20.94	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified ID Prof (QIDP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	4,819	5,218	158,136	30.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,303	236,041	\$ 6,333,461 *	\$ 26.83	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	160	\$ 11,981	Line 1 Col 3	35
36	Medical Director	192	28,800	Line 9 Col 3	36
37	Medical Records Consultant	221	5,513	Line 21 Col 3	37
38	Nurse Consultant	Monthly	8,000	Line 19 Col 3	38
39	Pharmacist Consultant	Monthly	13,761	Line 19 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,000	Line 19 Col 3	44
45	Social Service Consultant				45
46	Other(specify)	44	6,645	Line 19 Col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	617	\$ 77,699		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	166	\$ 13,793	Line 21 Col 3	50
51	Licensed Practical Nurses	106	6,304	Line 21 Col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	272	\$ 20,096		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberFriendship Manor

0024760

Report Period Beginning:1/1/2025

Page 21

Ending:12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

LEVERENZ, MARK D

Administrator

\$ 131,923

Allocation to AL/IL

(32,981)

TOTAL (agree to Schedule V, line 17, col. 1)

\$ 98,942

(List each licensed administrator separately.)

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

See attached

Legal and Accounting

\$ 12,769

Synergi Partners

ERTC Consulting - Administrati

315,618

Isolved

PAYROLL SERVICE

1,800

Paylocity

PAYROLL SERVICE

1,565

Paycom

PAYROLL SERVICE

69,031

Allocation to AL/IL

(355,860)

Inovalon

COMPUTER SERVICES

4,820

Matrixcare

COMPUTER SERVICES

57,350

Platinum

COMPUTER SERVICES

61,235

PointClickCare

COMPUTER SERVICES

8,820

ALW P.C.

ACCOUNTING SERVICE

24,200

WIPFLI LLC

ACCOUNTING SERVICE

5,671

TOTAL (agree to Schedule V, line 19, column 3)

\$ 207,018

(For legal fee disclosure, see page 39 of instructions)

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$

Unemployment Compensation Insurance

FICA Taxes

738,084

Employee Health Insurance

1,122,789

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Dental Insurance

17,152

Employee Benefits

3,697

Employee Meetings, Events & Recognition

2,917

Pension

143,575

Life & Disability Ins

61,014

TOTAL (agree to Schedule V, line 22, col.8)

\$ 2,089,228

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

\$ 1,842

Advertising: Employee Recruitment

Health Care Worker Background Check

1,950

(Indicate # of checks performed)

Dues & Subscription

1,216

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 5,008

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Travel

6,153

Allocation to AL/IL

(4,271)

Seminar Expense

Seminar

6,313

Allocation to AL/IL

(2,598)

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 5,597

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 39,030 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 476,275

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ No

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 7,097
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

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

100% Ln 1

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

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
- (13)

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

Firm Name: Anderson, Lower, Whitlow PC

Yes
- (14)

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

Yes
- (15)

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.