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: 0050161

Facility Name: Friendship Manor Health Ctr

Address: 485 S Friendship Dr (Number) Nashville (City) 62263 (Zip Code)

County: Washington

Telephone Number: (618) 327-3041 **Fax #** (618) 327-4001

HFS ID Number:

Date of Initial License for Current Owners: 11/1/08

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rhonda Houchens **Telephone Number:** (270) 726-4033
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 1/1/25 to 10/31/25 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) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Rhonda Houchens, Director of Operations
(Firm Name & Address) Hargis & Associates, LLC
PO Box 263 Russellville, KY 42276
(Telephone) (270) 726-4033 Fax # (270) 726-8069

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 Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	36,480	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	120	TOTALS	120	36,480	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	4,106	5,719		182	6,544	1,358		17,909	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,106	5,719		182	6,544	1,358		17,909	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 49.09%

D. How many bed reserve days during this year were paid by the Department?
0 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 11/1/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 120

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,431	9,398	11,683	295,512		295,512		295,512			1
2	Food Purchase		165,012		165,012		165,012	(294)	164,718			2
3	Housekeeping	170,429	17,125		187,554	111	187,665		187,665			3
4	Laundry	78,605	5,760		84,365		84,365		84,365			4
5	Heat and Other Utilities			233,686	233,686		233,686	(19,441)	214,245			5
6	Maintenance	35,511		80,192	115,703		115,703		115,703			6
7	Other (specify):* Infectious Waste			1,844	1,844		1,844		1,844			7
8	TOTAL General Services	558,976	197,295	327,405	1,083,676	111	1,083,787	(19,735)	1,064,052			8
	B. Health Care and Programs											
9	Medical Director			9,500	9,500		9,500		9,500			9
10	Nursing and Medical Records	1,848,326	46,238	254,912	2,149,476	14,065	2,163,541	613	2,164,154			10
10a	Therapy											10a
11	Activities	67,987	3,240	3,804	75,031		75,031	(620)	74,411			11
12	Social Services	75,106			75,106	(37,553)	37,553		37,553			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,991,419	49,478	268,216	2,309,113	(23,488)	2,285,625	(7)	2,285,618			16
	C. General Administration											
17	Administrative	87,502		391,983	479,485		479,485	(334,900)	144,585			17
18	Directors Fees											18
19	Professional Services			457,904	457,904	(19,782)	438,122	(7,091)	431,031			19
20	Dues, Fees, Subscriptions & Promotions			23,025	23,025		23,025	(2,939)	20,086			20
21	Clerical & General Office Expenses	101,759	10,071	421,003	532,833	5,801	538,634	(396,498)	142,136			21
22	Employee Benefits & Payroll Taxes			384,517	384,517		384,517	17,917	402,434			22
23	Inservice Training & Education											23
24	Travel and Seminar			121	121		121		121			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			253,779	253,779		253,779	(13,258)	240,521			26
27	Other (specify):*											27
28	TOTAL General Administration	189,261	10,071	1,932,332	2,131,664	(13,981)	2,117,683	(736,769)	1,380,914			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,739,656	256,844	2,527,953	5,524,453	(37,358)	5,487,095	(756,511)	4,730,584			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Friendship Manor Health Ctr #0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			141,325	141,325		141,325	18,555	159,880			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,701	155,701	(195)	155,506	(22,024)	133,482			32
33	Real Estate Taxes			69,548	69,548		69,548	(9,493)	60,055			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			366,574	366,574	(195)	366,379	(12,962)	353,417			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			546	546		546		546			38
39	Ancillary Service Centers		51,000	303,384	354,384		354,384		354,384			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,616	311,616		311,616		311,616			42
43	Other (specify):* **Marketing Salary**					37,553	37,553	(37,553)				43
44	**TOTAL Special Cost Centers**		51,000	615,546	666,546	37,553	704,099	(37,553)	666,546			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,739,656	307,844	3,510,073	6,557,573		6,557,573	(807,026)	5,750,547			45

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	$ (1,470)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,555	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(294)	02		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	(3,708)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,091)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(385,552)	21		24
25	Fund Raising, Advertising and Promotional	(2,939)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(408,191)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (790,692)		$	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)	(16,334)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (16,334)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (807,026)		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

Friendship Manor Health Ctr

ID# 0050161

Report Period Beginning: 1/1/25

Ending: 10/31/25

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Bank Fees	(13,821)	21	3
4	Flowers	(620)	11	4
5	Plant Cable	(19,441)	05	5
6	Marketing Salary	(37,553)	43	6
7	Interest Expense (Closed Wing)	(22,022)	32	7
8	Property Insurance (Closed Wing)	(13,258)	26	8
9	Real Estate Taxes (Closed Wing)	(9,493)	33	9
10	Sale/Closing Costs	(291,983)	17	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**	(408,191)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(294)	0	0	0	0	0	0	0	0	0	0	(294)	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	(19,441)	0	0	0	0	0	0	0	0	0	0	(19,441)	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**	(19,735)	0	0	0	0	0	0	0	0	0	0	(19,735)	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	(1,470)	2,083	0	0	0	0	0	0	0	0	0	613	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(620)	0	0	0	0	0	0	0	0	0	0	(620)	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**	(2,090)	2,083	0	0	0	0	0	0	0	0	0	(7)	16
	C. General Administration													
17	Administrative	(291,983)	(42,917)	0	0	0	0	0	0	0	0	0	(334,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,091)	0	0	0	0	0	0	0	0	0	0	(7,091)	19
20	Fees, Subscriptions & Promotions	(2,939)	0	0	0	0	0	0	0	0	0	0	(2,939)	20
21	Clerical & General Office Expenses	(403,081)	6,583	0	0	0	0	0	0	0	0	0	(396,498)	21
22	Employee Benefits & Payroll Taxes	0	17,917	0	0	0	0	0	0	0	0	0	17,917	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	(13,258)	0	0	0	0	0	0	0	0	0	0	(13,258)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(718,352)	(18,417)	0	0	0	0	0	0	0	0	0	(736,769)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(740,177)	(16,334)	0	0	0	0	0	0	0	0	0	(756,511)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	18,555	0	0	0	0	0	0	0	0	0	0	18,555	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,024)	0	0	0	0	0	0	0	0	0	0	(22,024)	32
33	Real Estate Taxes	(9,493)	0	0	0	0	0	0	0	0	0	0	(9,493)	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**	(12,962)	0	0	0	0	0	0	0	0	0	0	(12,962)	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):*	(37,553)	0	0	0	0	0	0	0	0	0	0	(37,553)	43
44	**TOTAL Special Cost Centers**	(37,553)	0	0	0	0	0	0	0	0	0	0	(37,553)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(790,692)	(16,334)	0	0	0	0	0	0	0	0	0	(807,026)	45

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	37.4953660					
Kimberly Smith	37.4953660					
Danny Frances	25.0092680					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 100,000	Legacy Health Systems	100.00%	$	$ (100,000)	1
2	V	17	Salaries		Legacy Health Systems		57,083	57,083	2
3	V	22	Taxes & Insurance		Legacy Health Systems		17,917	17,917	3
4	V	21	Telephone		Legacy Health Systems		1,000	1,000	4
5	V	21	Travel		Legacy Health Systems		4,750	4,750	5
6	V	21	Office Supplies		Legacy Health Systems		833	833	6
7	V	10	Nurse Consulting		Legacy Health Systems		2,083	2,083	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 100,000			$ 83,666	$ * (16,334)	14

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Health Ctr

ID# **0050161**

Report Period Beginning: **1/1/25**

Ending: **10/31/25**

-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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Jay		Frances	Nashville	TN	37.49537			1
2	Kimberly		Smith	Martin	TN	37.49537			2
3	Danny		Frances	Crofton	KY	25.00927			3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Friendship Manor Health Ctr

ID# **0050161**

Report Period Beginning: **1/1/25**

Ending: **10/31/25**

-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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
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91									91
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148									148
149									149
150									150

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 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
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	$32,318.12	12/3/24	$ 2,189,373	$			$ 133,458	1
2	Telcom Direct		X	Telephone Equip Purchase	$469.62	9/30/22	8,454		9/30/25			2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,787.74		$ 2,197,827	$			$ 133,458	9
	B. Non-Facility Related*											
10	Interest Income	X									(2)	10
11	Planters Bank		X	Closed Wing Addition							22,022	11
12	Planters Bank		X	Closed Wing Addition Offset							(22,022)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2)	14
15	TOTALS (line 9+line14)						$ 2,197,827	$			$ 133,456	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.)

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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.**	$	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.)	$	69,548	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,962)	3
4. Real Estate Tax accrual used for 2025 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.	$	69,548	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020	77,160	9
	2021	76,736	10
	2022	78,493	11
	2023	71,251	12
	2024	69,548	13

FOR BHF USE ONLY

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Friendship Manor Health Ctr COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0050161

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-12-23-251-007	Long Term Care Property	$ 961.92	$ 961.92
2.	10-12-23-251-008	Long Term Care Property	$ 67,033.00	$ 57,540.00
3.	10-12-23-256-003	Long Term Care Property	$ 177.50	$ 177.50
4.	10-12-23-276-005	Long Term Care Property	$ 340.24	$ 340.24
5.	10-12-23-279-005	Long Term Care Property	$ 1,035.40	$ 1,035.40
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,548.06	$ 60,055.06

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Numb Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,960 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

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

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

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

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

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.

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 X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2008	$ 211,500	1
2					2
3	TOTALS			$ 211,500	3

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2008	1964	$ 3,788,500	$	39	$ 97,141	$ 97,141	$ 1,667,587	4
5			2008	1964	(536,498)			(13,794)	(13,794)	(110,352)	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	248,035		20	12,265	12,265	208,503	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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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 Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof Project-Wing 4	2010	$ 57,268	$	20	$ 2,863	$ 2,863	$ 45,810	37
38	Sprinkler	2010	4,790		20	240	240	3,838	38
39	2 Water Heaters	2010	2,683		20	134	134	2,145	39
40	Holland Const/Aci Arch	2010	4,937		20			4,937	40
41	New Doors	2010	20,473		20	1,024	1,024	16,383	41
42	New Doors	2011	7,360		10			7,360	42
43	HVAC repairs	2011	4,414		10			4,414	43
44	Front Entrance Demolition, Millwork, Walls, Ceilings, Floorings	2011	34,675		20	1,734	1,734	26,009	44
45	New Roof	2011	5,899		10			5,899	45
46	Remodel Walls, Ceiling, Tile & Carpet	2011	6,381		20	319	319	4,785	46
47	Roof Repairs	2011	3,100		20	155	155	2,325	47
48	Soffit & Fascia	2012	13,148		20	657	657	9,199	48
49	Two Bryant Rooftop A/Cs	2012	10,525		20	526	526	7,365	49
50	Sewer Line Replacement	2012	15,160		20	758	758	10,612	50
51	Kitchen Tile	2012	3,765		20	188	188	2,633	51
52	Soffit & Fascia	2012	4,183		20	209	209	2,926	52
53	Installation of 6" Seamless Guttering	2013	12,782		20	639	639	8,307	53
54	Installation of Walk in cooler	2013	8,460		20	423	423	5,499	54
55	Installation of Walk in Freezer	2013	9,130		20	457	457	5,941	55
56	Roof Replacement	2013	141,706		20	7,085	7,085	92,105	56
57	2 Carrier Ductless Heat Pumps	2013	6,975		20	349	349	4,537	57
58	Concrete Resurfacing	2013	5,590		20	280	280	3,640	58
59	LED 7W & LED 11W Smooth Lamps	2013	9,361		20	468	468	6,084	59
60	DMT Gas Generator #54	2013	6,000		20	300	300	3,900	60
61	Installation of High Efficiency Lighting	2013	41,615		20	2,081	2,081	27,053	61
62	Rooftop AC Unit	2014	5,355		20			5,355	62
63	Rebate of Installation of High Efficiency Lighting	2014	(18,266)		20	(913)	(913)	(10,956)	63
64	High Efficiency Lighting	2015	14,117		20	706	706	7,688	64
65	New Door for Snowman Freezer	2017	2,999		10	300	300	2,400	65
66	Fan on Boiler	2017	3,869		10	387	387	3,418	66
67	Actuator/Valve for Boiler	2018	8,929		7	1,273	1,273	8,929	67
68	Roof, Gutters, and Downspouts	2020	52,493		20	2,625	2,625	14,657	68
69	Boiler Pressure Switch & Disconnect	2020	5,507		10	551	551	2,847	69
70	TOTAL (lines 4 thru 69)		$ 4,015,420	$		$ 121,430	$ 121,430	$ 2,113,782	70

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	$		$ 121,430	$ 121,430	$ 2,113,782	1
2	Chelsey Fence and Deck	2021	20,850		15	1,390	1,390	6,255	2
3	Amana PTAC Units	2021	2,805		5	561	561	2,758	3
4	Shower Room and Drain Parts	2021	2,691		10	269	269	1,211	4
5	AC Unit Filter/Copacitor	2021	3,125		10	313	313	1,382	5
6	Tub Room Floor Materials	2021	2,566		20	128	128	551	6
7	500 Hall Shower Room Tile, Drywall, Drain Replacement	2021	15,250		20	763	763	3,119	7
8	Update Kitchen Plumbing to Code	2022	41,589		20	2,079	2,079	7,277	8
9	75 Gallon Water Heater	2022	7,669		10	767	767	2,557	9
10	100 Gallon Water Heater	2022	10,730		10	1,073	1,073	3,398	10
11	HVAC 12 1/2 Ton Rooftop Units	2023	22,262		15	1,484	1,484	3,525	11
12	2 Compressors 1/2 Ton Units	2023	4,370		10	437	437	1,056	12
13	HVA 4 PTAC Units	2023	3,051		10	305	305	712	13
14	Fire Alarm	2023	3,300		10	330	330	681	14
15	Roof Replacement	2023	242,984		20	12,149	12,149	28,348	15
16	Plumbing Improvements for Kitchen	2023	3,167		20	158	158	368	16
17	Sewer Drain For Kitchen	2023	4,722		20	236	236	532	17
18	Servpro Water Mitigation	2024	36,843		20	1,842	1,842	2,609	18
19	6 Smoke Detectors	2024	3,180		5	636	636	848	19
20	Roof Replacement	2024	150,000		20	7,500	7,500	15,000	20
21	Roof Replacement (Closed Wing)	2024	(55,803)		20	(2,790)	(2,790)	(5,580)	21
22	Ignitors, Ignition Board & Drive Boiler	2025	5,768		10	385	385	385	22
23	Dryheads for Sprinklers	2025	3,246		10	135	135	135	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	Financial Statement Depreciation			133,025			(133,025)		33
34	TOTAL (lines 1 thru 33)		$ 4,549,785	$ 133,025		$ 151,580	$ 18,555	$ 2,190,909	34

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	$ 881,891	$ 8,027	$ 8,027	$	10	$ 838,678	71
72	Current Year Purchases	2,729	273	273		5	273	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 884,620	$ 8,300	$ 8,300	$		$ 838,951	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	Handicap Dodge Caravan	2019	$ 30,673	$	$	$	5	$ 30,673	76
77										77
78										78
79										79
80	TOTALS			$ 30,673	$	$	$		$ 30,673	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,676,578	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,325	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 159,880	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,555	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,060,533	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	Building Closed Wing/2008	$ 536,498	$ 13,794	$ 110,352	86
87	Roof Replacement	55,803	2,790	5,580	87
88					88
89					89
90					90
91	TOTALS	$ 592,301	$ 16,584	$ 115,932	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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: ____ *

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	$

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

* 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.

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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
		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)	$			

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	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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	$		$ 114,730	$		$ 114,730	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			73,246			73,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03-02	hrs			105,813	1,282		107,095	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				39,837		39,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	39-02/03				9,595	9,881		19,476	13
14	TOTAL			$		$ 303,384	$ 51,000		$ 354,384	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.

STATE OF ILLINOIS

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/25 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (4,486)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	429,650		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	500,000		5
6	Prepaid Insurance	13,694		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 938,858	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 938,858	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 813,648	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	379,612		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Refunds	(45,759)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,147,501	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Transfers	2,289,037		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,289,037	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,436,538	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,497,680)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 938,858	$	48

*(See instructions.)

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (67,008)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (67,008)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,086,074)	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	(345,007)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,431,081)	17
	B. Transfers (Itemize):		
18	**Prior Year Change**	409	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 409	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,497,680)	24 *

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

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,391,573	1
2	Discounts and Allowances for all Levels	(75,758)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,315,815	3
	B. Ancillary Revenue		
4	Day Care	1,470	4
5	Other Care for Outpatients		5
6	Therapy	802,100	6
7	Oxygen	1,750	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 805,320	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	80,593	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,152	20
21	Other Medical Services	2,012	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 83,757	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Gain on Sale of Assets**	198,958	28
28a	**Other Revenue**	67,648	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 266,606	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,471,500	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,083,787	31
32	Health Care	2,285,625	32
33	General Administration	2,116,175	33
	B. Capital Expense		
34	Ownership	367,887	34
	C. Ancillary Expense		
35	Special Cost Centers	392,483	35
36	Provider Participation Fee	311,616	36
	D. Other Expenses (specify):		
37	**Rounding**	1	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,557,574	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,086,074)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,086,074)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 827,300.29	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,132,500.79	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	29,950.69	47
48	Private Pay	1,197,385.00	48
49	Medicare Part A	128,677.80	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)	$ 3,315,815	56

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,087	1,199	$ 53,655	$ 44.75	1
2	Assistant Director of Nursing	80	80	2,826	35.33	2
3	Registered Nurses	3,338	4,058	146,195	36.03	3
4	Licensed Practical Nurses	11,425	12,321	446,499	36.24	4
5	CNAs & Orderlies	41,310	43,520	1,157,023	26.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,479	3,823	67,987	17.78	10
11	Social Service Workers	759	899	37,553	41.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,437	14,457	274,431	18.98	15
16	Dishwashers					16
17	Maintenance Workers	1,440	1,568	35,511	22.65	17
18	Housekeepers	10,135	10,735	170,429	15.88	18
19	Laundry	4,469	4,805	78,605	16.36	19
20	Administrator	1,599	1,663	87,502	52.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,830	3,466	101,759	29.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,594	1,826	42,128	23.07	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	759	899	37,553	41.77	33
34	TOTAL (lines 1 - 33)	97,741	105,319	$ 2,739,656 *	$ 26.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 7,923	01-03	35
36	Medical Director	160	9,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	47	4,060	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	56	3,804	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	359	$ 25,287		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2,543	114,565	10-03	51
52	Certified Nurse Assistants/Aides	3,902	129,748	10-03	52
53	TOTAL (lines 50 - 52)	6,445	$ 244,313		53

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Scharlemann	Administrator		$ 87,502
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,502

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
Fast Track Billing	Consulting Fees	$ 16,500
Proactive Medical Review	Consulting Fees	34,832
Duane Morris	Legal Fees	204,588
Thacker, Hodskins, Searcy & Knight	Legal Fees	7,091
McMahon Berger P.C.	Legal Fees	129,823
Hargis & Associates	Accounting Fees	4,350
Calhoun & Company	Accounting Fees	1,610
Astounding LLC dba Safe Mode	Computer Services	4,602
Adobe	Computer Services	241
Microsoft	Computer Services	316
Point Click Care	Data Processing	22,847
Supplemental Schedule		31,104
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 457,904

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,246
Unemployment Compensation Insurance	
FICA Taxes	237,162
Employee Health Insurance	76,487
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	6,539
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,434

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	1,561
Health Care Worker Background Check	
(Indicate # of checks performed 53)	958
Patient Background Checks 35	350
Association Dues (total from pg 22, #4)	151
Taxes & Licenses	2,835
Professional Fees	14,161
Dues & Subscriptions	70
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,086

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	121
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 121

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Friendship Manor Health Ctr # 0050161 Report Period Beginning: 1/1/25 Ending: 10/31/25

XX. GENERAL INFORMATION:

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

(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
IL HEALTHCARE ASSOCIATION (IHCA)	151
	151 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.

IL HEALTHCARE ASSOCIATION (IHCA)	
	Total

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

IL HEALTHCARE ASSOCIATION (IHCA)	151
	151 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 8,369 Line 10

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes 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. $ 311,616
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? Yes 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. $ N/A Has any meal income been offset against related costs? Indicate the amount. $

(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. $

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

(13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name:

(14) Have all costs which do not relate to the provision of long term care been adjusted out 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.