

Facility Name & ID Number Parents & Friends of the SLC

0026773 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	34,542	31		34,573	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,542	31		34,573	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.72%

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

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

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 01/01/1982

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number

Parents & Friends of the SLC

0026773

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	201,673	13,114	8,427	223,214		223,214		223,214		1
2	Food Purchase		131,184		131,184		131,184		131,184		2
3	Housekeeping	23,030	21,295	7,476	51,801		51,801		51,801		3
4	Laundry		2,709		2,709		2,709		2,709		4
5	Heat and Other Utilities			113,017	113,017		113,017		113,017		5
6	Maintenance	61,432	15,928	27,646	105,006		105,006		105,006		6
7	Other (specify):*										7
8	TOTAL General Services	286,135	184,230	156,566	626,931		626,931		626,931		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	2,343,686	103,281	98,990	2,545,957		2,545,957		2,545,957		10
10a	Therapy	16,805		14,262	31,067		31,067		31,067		10a
11	Activities	45,307	12,238		57,545	2,218	59,763		59,763		11
12	Social Services	17,146		1,440	18,586		18,586		18,586		12
13	CNA Training	11,837			11,837		11,837		11,837		13
14	Program Transportation		11,957		11,957		11,957		11,957		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,434,781	127,476	131,492	2,693,749	2,218	2,695,967		2,695,967		16
	C. General Administration										
17	Administrative	58,387		1,613	60,000	(1,528)	58,472		58,472		17
18	Directors Fees										18
19	Professional Services			49,650	49,650		49,650	(1,000)	48,650		19
20	Dues, Fees, Subscriptions & Promotions			12,225	12,225	632	12,857	(2,096)	10,761		20
21	Clerical & General Office Expenses	141,851	14,789	29,010	185,650		185,650		185,650		21
22	Employee Benefits & Payroll Taxes			655,649	655,649	(450)	655,199		655,199		22
23	Inservice Training & Education			3,759	3,759		3,759		3,759		23
24	Travel and Seminar			1,776	1,776		1,776		1,776		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			110,961	110,961		110,961		110,961		26
27	Other (specify):*										27
28	TOTAL General Administration	200,238	14,789	864,643	1,079,670	(1,346)	1,078,324	(3,096)	1,075,228		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,921,154	326,495	1,152,701	4,400,350	872	4,401,222	(3,096)	4,398,126		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

Parents & Friends of the SLC

#0026773

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			208,519	208,519		208,519		208,519			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					1,528	1,528		1,528			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			64,832	64,832	(2,400)	62,432	(62,432)				36
37	TOTAL Ownership			273,351	273,351	(872)	272,479	(62,432)	210,047			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			286,902	286,902		286,902		286,902			42
43	Other (specify):* Bad debt			50,000	50,000		50,000	(50,000)				43
44	TOTAL Special Cost Centers			336,902	336,902		336,902	(50,000)	286,902			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,921,154	326,495	1,762,954	5,010,603		5,010,603	(115,528)	4,895,075			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,096)	20		17
18	Fines and Penalties	(62,432)	36		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,000)	43		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 over accrued year end expense	(1,000)	19		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (115,528)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (115,528)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Parents & Friends of the SLC

ID# 0026773

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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
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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parents & Friends of the SLC# 0026773

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,096)	0	0	0	0	0	0	0	0	0	0	(2,096)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,096)	0	0	0	0	0	0	0	0	0	0	(2,096)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,096)	0	0	0	0	0	0	0	0	0	0	(2,096)	29

STATE OF ILLINOIS

Facility Name & ID Number Parents & Friends of the SLC# 0026773

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(62,432)	0	0	0	0	0	0	0	0	0	0	(62,432)	36
37	TOTAL Ownership	(62,432)	0	0	0	0	0	0	0	0	0	0	(62,432)	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):*	(50,000)	0	0	0	0	0	0	0	0	0	0	(50,000)	43
44	TOTAL Special Cost Centers	(50,000)	0	0	0	0	0	0	0	0	0	0	(50,000)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(114,528)	0	0	0	0	0	0	0	0	0	0	(114,528)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				SLC Enrichment Cent	Swansea	To provide recreational opportunities to developmentally disabled adults.

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	Gymnasium rental	\$ 2,400	SLC Enrichment Center		\$ 2,400	\$	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		\$ 2,400			\$ 2,400	\$ *	14

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Parents & Friends of the SLC

0026773 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	Community First Bank		X	Line of Credit	Interest Only	4/15/13	as needed	zero	4/15/14	0.0525	1,528						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 1,528						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 1,528						

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2012 report.		\$ N/A	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ N/A	3																													
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$ N/A	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2008</td><td>_____</td><td>8</td></tr> <tr><td>2009</td><td>_____</td><td>9</td></tr> <tr><td>2010</td><td>_____</td><td>10</td></tr> <tr><td>2011</td><td>_____</td><td>11</td></tr> <tr><td>2012</td><td>_____</td><td>12</td></tr> </table>	2008	_____	8	2009	_____	9	2010	_____	10	2011	_____	11	2012	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2012 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2008	_____	8																														
2009	_____	9																														
2010	_____	10																														
2011	_____	11																														
2012	_____	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents & Friends of the SLC COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0026773

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 2012 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 2012.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick & frame Frame Protected non-combus Number of Stories single

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care		1979	\$ 999	1
2					2
3	TOTALS			\$ 999	3

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100	1982	1982	\$ 2,999,001	\$ 100,000	30	\$ 100,000	\$	\$ 2,090,888	4
5		1984	1984	303,400	10,113	30	10,113		294,134	5
6		1984	1984	33,537		15			33,537	6
7										7
8										8
	Improvement Type**									
9	Renovation of Pod 2		2001	22,806					22,806	9
10	Doors-ERC		1985	564	19	30	19		532	10
11	Fire Suppression System (dietary)		2003	2,740		7			2,740	11
12	Water Centers (Schaeffer)		2003	1,960		7			1,960	12
13	Belo-Sales and Service		2004	4,261		7			4,261	13
14	Belo Sales and Service		2004	14,839		7			14,839	14
15	Flooring in Houses and Nursing Office		2006	55,833	3,722	15	3,722		28,227	15
16	Carpet Squares/Living Area of Houses		2006	2,298		5			2,298	16
17	Fire Alarm Control Panel		2007	5,431	272	20	272		1,901	17
18	Painting of 2 Houses		2007	49,800		5			49,800	18
19	Blinds in houses		2008	10,700	1,070	10	1,070		6,331	19
20	Water heater/120 gallon and installation		2008	4,843	161	5	161		4,843	20
21	Door frames (6)(Overhead Door)		2008	3,296	471	7	471		2,601	21
22	Core building roof		2008	46,873	2,344	20	2,344		12,553	22
23	replacement of fire alarm panel		2008	3,398	170	20	170		949	23
24	replacement of 7.5 ton A/C unit (House 6)		2008	6,253	625	10	625		3,491	24
25	A/C replacement (House 3)		2008	2,636	264	10	264		1,450	25
26	Booster Water Heater (House 5)		2008	2,953	541	5	541		2,953	26
27	Squirrel Cage for House 6		2008	4,370	437	10	437		2,331	27
28	Roof repairs (Houses 2, 4, 5 and 6)		2008	24,968	4,161	5	4,161		24,968	28
29	Starter assemblies (Houses 2, 4 5, and 6)		2008	3,802	380	10	380		1,933	29
30	Feezer floor replacement		2009	11,536	1,154	10	1,154		4,903	30
31	Sprinkler System		2010	515,800	25,790	5	25,790		84,714	31
32	Fire Alarm upgrade		2010	22,426	1,121	20	1,121		3,768	32
33	Core building roof repairs		2010	3,212	161	5	161		575	33
34	Sidewalks		2010	21,075	2,108	10	2,108		8,870	34
35	House 2 A/C unit		2012	6,200	1,240	5	1,240		2,273	35
36	Painting in Houses		2013	4,361	654	5	654		654	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	Flooring in Houses	2013	\$ 32,652	\$ 1,633	15	\$ 1,633	\$	\$ 1,633	37
38	Painting in Houses	2013	2,106	281	5	281		281	38
39	Electronic Doors-Core building	2013	9,620	200	20	200		200	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,239,550	\$ 159,092		\$ 159,092	\$	\$ 2,720,197	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 108,980	\$ 16,123	\$ 16,123	\$		\$ 86,336	71
72	Current Year Purchases	5,659	494	494			494	72
73	Fully Depreciated Assets	185,859	3,740	3,740			185,859	73
74								74
75	TOTALS	\$ 300,498	\$ 20,357	\$ 20,357	\$		\$ 272,689	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	Patient Care	various	varioys	\$ 39,881	\$	\$	\$	5	\$ 39,881	76
77	Patient Care	Dodge Caravan Van	2006	39,405				5	39,405	77
78	Patient Care	Kia Sadonas (3)	2011	63,285	12,657	12,657		5	29,533	78
79	Patient Care	Wheelchair vans (2)	2011	82,057	16,411	16,411			36,926	79
80	TOTALS			\$ 224,628	\$ 29,068	\$ 29,068	\$		\$ 145,745	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)	\$ 4,765,675	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 208,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,517	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,138,631	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Parents & Friends of the SLC

0026773

Report Period Beginning:

01/01/2013

Ending: 12/31/2013

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>90</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,000		1,000
3	Classroom Wages (a)		14,992		14,992
4	Clinical Wages (b)		33,370		33,370
5	In-House Trainer Wages (c)		1,515		1,515
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 50,877	\$	\$ 50,877
10	SUM OF line 9, col. 1 and 2 (e)	\$	50,877		

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	38
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	38

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		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		hrs	\$		\$										1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care	Line 10/Column 3	visits	5,408							92		5,408			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			\$ 5,408		\$		\$			92	\$	5,408			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.

Facility Name & ID Number Parents & Friends of the SLC# 0026773Report Period Beginning: 01/01/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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	\$ 964,391	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>for doubtful acc</u>)	683,320		3
4	Supply Inventory (priced at <u>cost</u>)	10,860		4
5	Short-Term Investments			5
6	Prepaid Insurance	54,537		6
7	Other Prepaid Expenses	2,225		7
8	Accounts Receivable (owners or related parties)	14,408		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,729,741	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,240,550		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	525,126		16
17	Accumulated Depreciation (book methods)	(3,138,630)		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)	\$ 1,627,046	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,356,787	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 78,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	320,171		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,645		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 423,254	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 423,254	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,933,534	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,356,788	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,142,447	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,142,447	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(208,913)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (208,913)	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)	\$ 2,933,534	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,686,614	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,686,614	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	50,877	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 50,877	23
D. Non-Operating Revenue			
24	Contributions	100	24
25	Interest and Other Investment Income***	2,730	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,830	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Garnishment Fees/Restitution/Recycling	1,369	28
28a	Insurance settlement	60,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 61,369	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,801,690	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	626,931	31
32	Health Care	2,693,749	32
33	General Administration	1,079,670	33
B. Capital Expense			
34	Ownership	273,351	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	286,902	36
D. Other Expenses (specify):			
37	<u>Bad Debt</u>	50,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,010,603	40
41	Income before Income Taxes (line 30 minus line 40)**	(208,913)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (208,913)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,957,266	44
45	Private Pay - Net Inpatient Revenue	4,650	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Cost of Care</u>	719,593	47
48	Other-(specify) <u>Work Recoupment</u>	5,105	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,686,614	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Parents & Friends of the SLC

0026773

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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	1,155	1,247	\$ 33,830	\$ 27.13	1
2	Assistant Director of Nursing	1,932	2,063	36,279	17.59	2
3	Registered Nurses	292	292	6,451	22.09	3
4	Licensed Practical Nurses	18,361	19,865	340,861	17.16	4
5	CNAs & Orderlies					5
6	CNA Trainees	12,826	12,826	115,525	9.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,508	1,692	16,805	9.93	8
9	Activity Director	777	990	17,145	17.32	9
10	Activity Assistants	2,847	2,984	28,162	9.44	10
11	Social Service Workers	960	990	17,146	17.32	11
12	Dietician					12
13	Food Service Supervisor	2,998	3,468	46,977	13.55	13
14	Head Cook	4,959	5,622	58,329	10.38	14
15	Cook Helpers/Assistants					15
16	Dishwashers	9,206	10,530	96,367	9.15	16
17	Maintenance Workers	3,855	4,001	61,432	15.35	17
18	Housekeepers	1,816	2,074	23,030	11.10	18
19	Laundry					19
20	Administrator	2,050	2,240	58,387	26.07	20
21	Assistant Administrator					21
22	Other Administrative	3,373	3,856	76,018	19.71	22
23	Office Manager	1,398	1,690	37,590	22.24	23
24	Clerical	1,791	2,055	24,257	11.80	24
25	Vocational Instruction					25
26	Academic Instruction	598	621	11,837	19.06	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,972	6,849	133,723	19.52	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	132,086	147,832	1,529,181	10.34	30
31	Medical Records					31
32	Other Health C: AOD	10,292	11,304	147,835	13.08	32
33	Other(specify) <u>Seamstress</u>	472	472	3,987	8.45	33
34	TOTAL (lines 1 - 33)	221,524	245,563	\$ 2,921,154 *	\$ 11.90	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	172	\$ 8,427	line 1, col 3	35
36	Medical Director	112	16,800	line 9, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	248	12,333	line 10, col 3	38
39	Pharmacist Consultant	12	1,200	line 10, col 3	39
40	Physical Therapy Consultant	35	1,713	line 10a, col 3	40
41	Occupational Therapy Consultant	117	5,850	line 10a, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	112	6,700	line 10a, col 3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,440	line 12, col 3	45
46	Other(specify) <u>Psychiatrist</u>	48	4,800	line 10, col 3	46
47	<u>Psychologist</u>	342	24,000	line 10, col 3	47
48					48
49	TOTAL (lines 35 - 48)	1,222	\$ 83,263		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	532	\$ 21,943	line 10, col 3	50
51	Licensed Practical Nurses	998	29,306	line 10, col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,530	\$ 51,249		53

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

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes-HabTechs only
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$3,208
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,858 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 286,902
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 88,260 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? 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? 99%
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? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Clifton Larson Allen
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Parents and Friends of the Specialized Living Center
 IDPH # 0026773
 Cost Report Attachment 1
 Schedule V Reclassifications

<u>Schedule V Reclassifications</u>		<u>Description</u>
Activity Other	\$ (182)	Patient Background checks
Activity Other	\$ 2,400	Gym rental fee
Administrative Other	\$ (1,528)	Interest expense
Dues/Subscriptions	\$ 632	\$450 employee background checks and \$182 patient background checks
Employee Benefits	\$ (450)	Employee background checks
Interest Expense	\$ 1,528	Interest expense
<u>Ownership-Other</u>	<u>\$ (2,400.00)</u>	Gym rental fee
<u>Net Adjustments</u>	<u>\$ -</u>	

Line 25--Interest and other investment income

\$ 2,703 Bank interest-Unrestricted

\$ 2,703 Total

Parents and Friends of the Specialized Living Center
 IDPH # 0026773
 Cost Report Attachment 3
 Schedule V, Lines 23 and 24

Line 23--In-service Training and Education

American Red Cross-CPR training	\$ 67
J.A. Logan College-CPR training	405
INHAA-Nursing Home Administrators Conference registration	95
Laura Blumenstein-tuition reimbursement for Nursing Leadership and Healthcare Policy class	1,000
Crisis Prevention-Crisis Intervention instruction	2,125
Sanitation class	67
Total	<u>\$ 3,759</u>

Line 24-Travel and Seminar

	Total	Registration	Hotel	Fuel	Meals
Illinois Healthcare Association annual conference	\$ 1,666	795	659	48	164
Long Term Care Association annual conference	110	110			
Total	<u>\$ 1,776</u>	<u>905</u>	<u>659</u>	<u>48</u>	<u>164</u>

Parents and Friends of the Specialized Living Center
IDPH # 0026773
Cost Report Attachment 4

Board of Director Listing

Agnes Schloemann, President
Orville Lester, Vice President
Arland Lester, Secretary/Treasurer
Rev. Dr. WJ Griffin
Donna Harris
Jim Igel
Wilma Postin

All Board of Director members serve on a voluntary basis and receive no paid compensation.