

Facility Name & ID Number Parents & Friends of the SLC

0026773 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	100	Intermediate (ICF)	100	36,500	3
4		Intermediate/DD			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	29,840			29,840	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,840			29,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.75%

D. How many bed-hold days during this year were paid by the Department? 422 (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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Parents & Friends of the SLC

0026773

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	187,644	16,117	6,397	210,158		210,158	210,158			1
2	Food Purchase		131,454		131,454		131,454	131,454			2
3	Housekeeping	39,023	14,316	7,513	60,852		60,852	60,852			3
4	Laundry		822		822		822	822			4
5	Heat and Other Utilities			119,676	119,676		119,676	119,676			5
6	Maintenance	67,236	18,114	20,743	106,093		106,093	106,093			6
7	Other (specify):*										7
8	TOTAL General Services	293,903	180,823	154,329	629,055		629,055	629,055			8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800	16,800			9
10	Nursing and Medical Records	2,200,792	85,639	52,098	2,338,529		2,338,529	2,338,529			10
10a	Therapy	17,884		13,177	31,061		31,061	31,061			10a
11	Activities	40,898	9,753		50,651	2,400	53,051	53,051			11
12	Social Services	20,262		1,440	21,702		21,702	21,702			12
13	CNA Training	12,115			12,115		12,115	12,115			13
14	Program Transportation		14,002		14,002		14,002	14,002			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,291,951	109,394	83,515	2,484,860	2,400	2,487,260	2,487,260			16
	C. General Administration										
17	Administrative	57,014		461	57,475		57,475	57,475			17
18	Directors Fees										18
19	Professional Services			74,270	74,270		74,270	(2,118)	72,152		19
20	Dues, Fees, Subscriptions & Promotions			2,210	2,210	786	2,996	(188)	2,808		20
21	Clerical & General Office Expenses	133,841	9,168	29,949	172,958		172,958	172,958			21
22	Employee Benefits & Payroll Taxes			454,250	454,250	(786)	453,464	453,464			22
23	Inservice Training & Education			450	450		450	450			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			107,660	107,660		107,660	107,660			26
27	Other (specify):*										27
28	TOTAL General Administration	190,855	9,168	669,250	869,273		869,273	(2,306)	866,967		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,776,709	299,385	907,094	3,983,188	2,400	3,985,588	(2,306)	3,983,282		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			194,491	194,491		194,491		194,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,203	1,203		1,203		1,203			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			2,667	2,667	(2,400)	267		267			36
37	TOTAL Ownership			198,361	198,361	(2,400)	195,961		195,961			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			260,681	260,681		260,681		260,681			42
43	Other (specify):* Bad Debts			58,084	58,084		58,084	(58,084)				43
44	TOTAL Special Cost Centers			318,765	318,765		318,765	(58,084)	260,681			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,776,709	299,385	1,424,220	4,500,314		4,500,314	(60,390)	4,439,924			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	(188)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,118)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,084)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,390)		\$	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))	\$ (60,390)		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.			\$		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

Parents & Friends of the SLC

ID# 0026773

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

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:

01/01/2015

Ending:

12/31/2015

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	(2,118)	0	0	0	0	0	0	0	0	0	0	(2,118)	19
20	Fees, Subscriptions & Promotions	(188)	0	0	0	0	0	0	0	0	0	0	(188)	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	(2,306)	0	0	0	0	0	0	0	0	0	0	(2,306)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,306)	0	0	0	0	0	0	0	0	0	0	(2,306)	29

STATE OF ILLINOIS

Facility Name & ID Number Parents & Friends of the SLC

0026773

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	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):* Bad Debts	(58,084)	0	0	0	0	0	0	0	0	0	0	(58,084)	43
44	TOTAL Special Cost Centers	(58,084)	0	0	0	0	0	0	0	0	0	0	(58,084)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(60,390)	0	0	0	0	0	0	0	0	0	0	(60,390)	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	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

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:

01/01/2015

Ending: 2/31/2015

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

Facility Name & ID Number

Parents & Friends of the SLC

0026773

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	Providence Bank		X	Line of Credit	Interest Only	4/15/2014	as needed	zero	4/15/2015	0.0525	1,203						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 1,203						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 1,203						

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 2014 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 2015 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>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>_____</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	_____	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 2014 \$</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 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2010	_____	8																														
2011	_____	9																														
2012	_____	10																														
2013	_____	11																														
2014	_____	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

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

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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-Combu 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	\$	\$ 2,290,888	4
5		1984	1984	303,400		30			303,400	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	13	19	13		564	10
11	Fire Suppression System (dietary)		2003	2,740		7			2,740	11
12	Water Centers (Schaeffer)		2004	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 Nurses offices		2006	55,833	3,721	15	3,721		35,671	15
16	Carpet squares/ Houses living room		2006	2,298		5			2,298	16
17	Fire Alarm Control Panel		2007	5,431	272	20	272		2,444	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		8,471	19
20	Water heater/120 gal and install		2008	4,843		5			4,843	20
21	Door frames (6) (Overhead Door)		2008	3,296	224	7	224		3,296	21
22	Core Building Roof		2008	46,873	2,344	20	2,344		17,240	22
23	Replacement of fire alarm panel		2008	3,398	170	20	170		1,289	23
24	Replace 7.5 ton A/C unit (House 6)		2008	6,253	625	10	625		4,742	24
25	REPLACEMENTS House 3		2008	2,636	264	10	264		1,977	25
26	Booster Water Heater (House 5)		2008	2,953		5			2,953	26
27	Squirrel Cage for House 6		2008	4,370	437	10	437		3,205	27
28	Roof Repairs Houses 2, 4, 5 & 6		2008	24,968		5			24,968	28
29	Starter Assemblies 2, 4, 5 & 6		2008	3,802	380	10	380		2,693	29
30	Freezer Floor		2009	11,536	1,154	10	1,154		7,210	30
31	Sprinkler System		2010	515,800	25,790	20	25,790		136,294	31
32	Fire alarm upgrade		2010	22,426	1,121	20	1,121		6,010	32
33	Core Building Roof Repairs		2010	3,212	161	5	161		897	33
34	Sidewalks		2010	21,075	2,108	10	2,108		13,086	34
35	Pod 2 Air Conditioner		2012	6,200	1,240	5	1,240		4,753	35
36	Painting in Houses		2013	4,361	872	5	872		2,398	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	\$ 2,177	15	\$ 2,177	\$	\$ 5,986	37
38	Painting in Houses	2013	2,107	421	5	421		1,123	38
39	Electronic Doors - Core Building	2013	9,620	481	20	481		1,163	39
40	House 2 & 3 Door Replacement	2015	8,727	309	20	309		309	40
41	Lobby and small hall flooring	2015	2,646	165	10	165		165	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)		\$ 4,250,924	\$ 145,519		\$ 145,519	\$	\$ 3,020,279	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	\$ 78,758	\$ 16,490	\$ 16,490	\$		\$ 39,591	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	272,840	3,414	3,414			272,840	73
74								74
75	TOTALS	\$ 351,598	\$ 19,904	\$ 19,904	\$		\$ 312,431	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	Various	\$ 39,881	\$	\$	\$	5	\$ 39,881	76
77	Patient Care	Dodge Caravan Van	2006	39,405				5	39,405	77
78	Patient Care	2012 Kia Sedonas (3)	2011	63,285	12,657	12,657		5	54,847	78
79	Patient Care	Wheelchair Vans (2)	2011	82,057	16,411	16,411		5	69,748	79
80	TOTALS			\$ 224,628	\$ 29,068	\$ 29,068	\$		\$ 203,881	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)	\$ 4,828,149	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 194,491	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 194,491	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)	\$ 3,536,591	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: 01/01/2015

Ending: 12/31/2015

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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		375		375
3	Classroom Wages (a)		8,484		8,484
4	Clinical Wages (b)		18,883		18,883
5	In-House Trainer Wages (c)		608		608
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 28,350	\$	\$ 28,350
10	SUM OF line 9, col. 1 and 2 (e)	\$	28,350		

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	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

- (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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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		73 visits	3,750				73	3,750	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			\$ 3,750		\$	\$	73	\$ 3,750	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**# **0026773**Report Period Beginning: **01/01/2015**

Ending:

12/31/2015**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2015**

(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	\$ 586,055	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	371,230		3
4	Supply Inventory (priced at <u>cost</u>)	5,852		4
5	Short-Term Investments			5
6	Prepaid Insurance	45,220		6
7	Other Prepaid Expenses	862		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,009,219	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1		13
14	Buildings, at Historical Cost	4,251,923		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	576,226		16
17	Accumulated Depreciation (book methods)	(3,536,591)		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)	\$ 1,291,559	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,300,778	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 62,705	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,677		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,832		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)	\$ 287,214	\$	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)	\$ 287,214	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,013,564	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,300,778	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,397,033	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,397,033	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(383,469)	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)	\$ (383,469)	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)	\$ 2,013,564	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	\$ 4,077,111	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,077,111	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	28,350	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)	\$ 28,350	23
D. Non-Operating Revenue			
24	Contributions	1,200	24
25	Interest and Other Investment Income***	2,420	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,620	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	4,471	27
28	Garnishment Fees	473	28
28a	IPA Late Payment Restitution	2,820	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,764	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,116,845	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	629,055	31
32	Health Care	2,484,860	32
33	General Administration	869,273	33
B. Capital Expense			
34	Ownership	198,361	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	260,681	36
D. Other Expenses (specify):			
37	<u>Bad Debts</u>	58,084	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,500,314	40
41	Income before Income Taxes (line 30 minus line 40)**	(383,469)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (383,469)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,429,300	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Cost of Care</u>	632,992	47
48	Other-(specify) <u>Work Recoupment</u>	14,819	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,077,111	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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: 01/01/2015

Ending: 12/31/2015

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	1,910	2,098	\$ 55,969	\$ 26.68	1
2	Assistant Director of Nursing	2,137	2,222	52,678	23.71	2
3	Registered Nurses					3
4	Licensed Practical Nurses	18,573	20,029	341,032	17.03	4
5	CNAs & Orderlies					5
6	CNA Trainees	5,325	6,031	54,330	9.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,552	1,752	17,884	10.21	8
9	Activity Director	1,770	1,988	21,206	10.67	9
10	Activity Assistants	2,212	2,348	19,691	8.39	10
11	Social Service Workers	1,594	1,723	20,262	11.76	11
12	Dietician					12
13	Food Service Supervisor	2,392	2,798	33,025	11.80	13
14	Head Cook	5,553	5,886	63,106	10.72	14
15	Cook Helpers/Assistants					15
16	Dishwashers	9,421	10,042	91,513	9.11	16
17	Maintenance Workers	4,138	4,533	67,236	14.83	17
18	Housekeepers	3,584	3,936	39,023	9.91	18
19	Laundry					19
20	Administrator	2,214	2,445	57,014	23.32	20
21	Assistant Administrator					21
22	Other Administrative	4,994	5,726	75,685	13.22	22
23	Office Manager	1,415	1,490	34,229	22.97	23
24	Clerical	1,867	2,120	23,928	11.29	24
25	Vocational Instruction					25
26	Academic Instruction	675	763	12,115	15.88	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,762	10,781	164,126	15.22	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	129,981	139,429	1,407,666	10.10	30
31	Medical Records					31
32	Other Health C: <u>AOD</u>	9,205	10,025	124,991	12.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,274	238,165	\$ 2,776,709 *	\$ 11.66	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	129	\$ 6,397	1, col. 3	35
36	Medical Director	112	16,800	9, col. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	10, col. 3	39
40	Physical Therapy Consultant	39	1,962	10a,col.3	40
41	Occupational Therapy Consultant	103	5,155	10a,col.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	101	6,060	10a,col.3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,440	12, col. 3	45
46	Other(specify) <u>Psychiatrist</u>	40	4,000	10, col. 3	46
47	<u>Psychologist</u>	342	24,000	10, col. 3	47
48					48
49	TOTAL (lines 35 - 48)	902	\$ 67,014		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	591	19,148	10, col. 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	591	\$ 19,148		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Krystal Gruenfelder	Administrator	0	\$ 51,419	Workers' Compensation Insurance	\$ 77,726	IDPH License Fee	\$	
Karlene Dotson	Administrator	0	5,595	Unemployment Compensation Insurance	8,103	Advertising: Employee Recruitment	1,230	
				FICA Taxes	208,642	Health Care Worker Background Check		
				Employee Health Insurance	85,548	(Indicate # of checks performed <u>25</u>)	786	
				Employee Meals	62,415	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		MES/HPSI Dues	175	
				Employee Gifts/Relations	3,532	Center fro Dev Disabilities Advocacy	312	
				Employee Physicals	904	Licensing and filing fees	305	
				Employer Matching 403b Contribution	740			
				Employee Life and Disability Insurance	5,854			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,014	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 453,464		\$ 2,808		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Bank Fees			\$ 125			\$	Out-of-State Travel	\$
Late fees			336					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 461				Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 74,270	TOTAL		\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes - Hab Techs only
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Center for Developmental Disabilities \$500
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,659 Line 10, col. B
- (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. \$ 260,681
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. \$ 62,415 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? 100%
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: ScheffelBoyle
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

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

<u>Schedule V Reclassifications</u>		<u>Description</u>
Activity Other	\$ 2,400	Gym rental fee
Dues/Subscriptions	\$ 786	Employee background checks
Employee benefits	\$ (786)	Employee background checks
Ownership - Other	\$ (2,400)	Gym rental fee
Net Adjustments	<u>\$ -</u>	

Line 25 - Interest and Other Investment Income

Bank Interest - Unrestricted \$ 2,420

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

Line 23 - In-service Training and Education

J. A. Logan College CPR Training	380
Food Safety class supplies	70
Total	<u>\$ 450</u>

Line 24 - Travel and Seminar

	Total	Registration	Hotel	Fuel and Meals
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N/A				
Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

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

Board of Director Listing

Dennis Jenkins - President
Jim Igel, Vice-President
Craig Aukamp - Secretary/Treasurer
Linda Carlock
Mary Brown

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

Parents and Friends of the Specially Living Center
 IDPH # 0026773
 Cost Report Attachment 5
 Schedule XIX C. Legal Fee Detail

<u>Invoice Date</u>	<u>Allowable Amount</u>	<u>Nonallowable Amount</u>	Description of Services	
Lowenbaum Partnership				
1/31/2015	51	0	Payroll fraud issue	
2/28/2015	79	0	Audit reply letter	
4/30/2015	33	0	EEOC Claim, Agreement	
4/30/2015	960	0	Handbook revision and review	
6/1/2015	33	0	EEOC Claim, Agreement	
7/1/2015	120	0	Employee termination	
7/31/2015	234	0	Employee termination	
9/30/2015	66	0	EEOC Claim, Agreement	
10/31/2015	123	0	FMLA IDHR Employee issue	
10/31/2015	744	0	FMLA IDHR Employee issue	
11/30/2015	221	0	FMLA IDHR Employee issue	
12/31/2015	43	0	Employment law matter	
12/31/2015	3,793	0	FMLA IDHR Employee issue	
	<u>6,500</u>	<u>-</u>		
Evans Law Firm				
1/5/2015	16	0	Passages Hospice	16
2/3/2015	207	0	Passages Hospice	207
3/2/2015	18	0	Suspended employee matter	
3/6/2015	591	0	Passages Hospice	591
4/9/2015	140	0	Passages Hospice	140
5/8/2015	498	0	Passages Hospice	498
5/29/2015	37	0	Banking search, State nonpayment	
6/1/2015	208	0	Passages Hospice	208
7/2/2015	175	0	Passages Hospice	175
7/2/2015	598	0	Banking search, State nonpayment	
8/4/2015	111	0	Banking search, State nonpayment	
9/1/2015	155	0	Passages Hospice	155
9/1/2015	19	0	Banking search, State nonpayment	
10/5/2015	78	0	Passages Hospice	78
12/2/2015	50	0	Passages Hospice	50
	<u>2,901</u>	<u>-</u>		<u>2,118</u>
Sorling Northrup Attorneys				
3/10/2015	350	0	Audit confirmation response	
	<u>350</u>	<u>-</u>		