

Facility Name & ID Number Parents and Friends of the Specialized Living Center

0026733 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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)	65	34,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	65	34,995	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	34,365			34,365	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,365			34,365	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.20%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Parents and Friends of the Specialized Living # 0026733 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	161,205	12,917	7,548	181,670		181,670		181,670		1
2	Food Purchase		163,975		163,975		163,975		163,975		2
3	Housekeeping	42,890	12,070		54,960		54,960		54,960		3
4	Laundry		1,103	57	1,160		1,160		1,160		4
5	Heat and Other Utilities			112,809	112,809		112,809		112,809		5
6	Maintenance	78,061	13,697	66,858	158,616		158,616		158,616		6
7	Other (specify):*										7
8	TOTAL General Services	282,156	203,762	187,272	673,190		673,190		673,190		8
	B. Health Care and Programs										
9	Medical Director			20,540	20,540	(140)	20,400		20,400		9
10	Nursing and Medical Records	1,827,050	72,786	38,059	1,937,895	(53,685)	1,884,210		1,884,210		10
10a	Therapy	19,328		12,791	32,119		32,119		32,119		10a
11	Activities	50,902			50,902		50,902		50,902		11
12	Social Services	26,951		2,100	29,051		29,051		29,051		12
13	CNA Training	17,072			17,072	54,633	71,705		71,705		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,941,303	72,786	73,490	2,087,579	808	2,088,387		2,088,387		16
	C. General Administration										
17	Administrative	42,258			42,258		42,258		42,258		17
18	Directors Fees										18
19	Professional Services			76,284	76,284		76,284	(2,000)	74,284		19
20	Dues, Fees, Subscriptions & Promotions			4,853	4,853		4,853	(771)	4,082		20
21	Clerical & General Office Expenses	156,558	9,470	31,898	197,926		197,926	(22,322)	175,604		21
22	Employee Benefits & Payroll Taxes			325,476	325,476	140	325,616		325,616		22
23	Inservice Training & Education			1,068	1,068	(948)	120		120		23
24	Travel and Seminar			1,171	1,171		1,171		1,171		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			68,070	68,070		68,070		68,070		26
27	Other (specify):*										27
28	TOTAL General Administration	198,816	9,470	508,820	717,106	(808)	716,298	(25,093)	691,205		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,422,275	286,018	769,582	3,477,875		3,477,875	(25,093)	3,452,782		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			159,544	159,544		159,544		159,544			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,421	2,421		2,421	(35)	2,386			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			378	378		378		378			35
36	Other (specify):*											36
37	TOTAL Ownership			162,343	162,343		162,343	(35)	162,308			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			204,584	204,584		204,584		204,584			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			204,584	204,584		204,584		204,584			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,422,275	286,018	1,136,509	3,844,802		3,844,802	(25,128)	3,819,674			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	(35)	32		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				17
18	Fines and Penalties	(8,125)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,056)	21		24
25	Fund Raising, Advertising and Promotional	(771)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,141)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,128)		\$	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))	\$ (25,128)		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 and Friends of the Specialized Living Center

ID# 0026733

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (13,141)	21	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	(13,141)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parents and Friends of the Specialized Living Center

0026733

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	19
20	Fees, Subscriptions & Promotions	(771)	0	0	0	0	0	0	0	0	0	0	(771)	20
21	Clerical & General Office Expenses	(22,322)	0	0	0	0	0	0	0	0	0	0	(22,322)	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	(25,093)	0	0	0	0	0	0	0	0	0	0	(25,093)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,093)	0	0	0	0	0	0	0	0	0	0	(25,093)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parents and Friends of the Specialized Living Center # 0026733 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(35)	0	0	0	0	0	0	0	0	0	0	(35)	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	(35)	0	0	0	0	0	0	0	0	0	0	(35)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(25,128)	0	0	0	0	0	0	0	0	0	0	(25,128)	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

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

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

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

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

VII. RELATED PARTIES

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	Craig Aukamp	BOD						1
2	Jim Igel	BOD						2
3	Mary Brown	BOD						3
4	Christina Roedl	BOD						4
5	Rick Yoch	BOD						5
6	Justin Drake	BOD						6
7	Ralph E Holmes, SR	BOD						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 and Friends of the Specialized Living # 0026733 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 and Friends of the Specialized Living Center # 0026733 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Central Bank		X	Line of Credit	Interest Only	8/23/2016	as needed	Zero	2/22/19	0.0350	2,421									
7	Interest Income offset										(35)									
8																				
9	TOTAL Facility Related										2,386									
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)										2,386									

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	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).		\$	3
4. Real Estate Tax accrual used for 2018 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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents and Friends of the Specialized Living Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0026733

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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 and Fram 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	42,317	1979	\$ 1	1
2					2
3	TOTALS	42,317		\$ 1	3

Facility Name & ID Number Parents and Friends of the Specialized Living Center

0026733

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	65		1982	1982	\$ 2,999,999	\$ 100,000	30	\$ 100,000	\$	\$ 2,590,888	4
5				1984	303,400					303,400	5
6				1984	33,537					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					564	10
11		Fire Suppression System (dietary)		2003	2,740					2,740	11
12		Water Centers (Schaeffer)		2004	1,960					1,960	12
13		Belo - Sales and Service		2004	4,261					4,261	13
14		Belo - Sales and Service		2004	14,839					14,839	14
15		Flooring in Houses' and Nurses offices		2006	55,833	3,722	15	3,722		46,837	15
16		Carpet squares/Houses living room		2006	2,298					2,298	16
17		Fire Alarm Control Panel		2006	5,431	272	20	272		3,259	17
18		Painting of 2 houses		2007	49,800					49,800	18
19		Blinds in houses		2008	10,700	89	10	89		10,700	19
20		Water heater/120 gal and install		2008	4,843					4,843	20
21		Door frames (6) Overhead Door		2008	3,296					3,296	21
22		Core Building Roof		2008	46,873	2,344	20	2,344		24,271	22
23		Replacement of fire alarm panel		2008	3,398	170	20	170		1,798	23
24		Replace 7.5 ton A/C unit (House 6)		2008	6,253	260	10	260		6,253	24
25		REPLACEMENTS House 3		2008	2,636	132	10	132		2,636	25
26		Booster Water Heater (House 5)		2008	2,953					2,953	26
27		Squirrel Cage for House 6		2008	4,370	291	10	291		4,370	27
28		Roof Repairs Houses 2, 4, 5 & 6		2008	24,968					24,968	28
29		Starter Assemblies 2, 4, 5 & 6		2008	3,802	349	10	349		3,802	29
30		Freezer Floor		2009	11,536	1,153	10	1,153		10,670	30
31		Sprinkler System		2010	515,800	25,790	20	25,790		213,664	31
32		Fire Alarm upgrade		2010	22,426	1,121	20	1,121		9,374	32
33		Core Building Roof Repairs		2010	3,212	160	5	160		1,378	33
34		Sidewalks		2010	21,075	2,108	10	2,108		19,409	34
35		Pod 2 Air Conditioner		2012	6,200					6,200	35
36		Painting in Houses		2013	4,361	218	5	218		4,361	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	\$	\$ 12,517	37
38	Painting in Houses	2013	2,107	141	5	141		2,106	38
39	Electronic Doors - Core Building	2013	9,620	481	20	481		2,605	39
40	House 2 & 3 Door Replacement	2015	8,727	436	20	436		1,618	40
41	Lobby and small hall flooring	2015	2,646	265	10	265		959	41
42	Air Handler House 7	2016	4,986	478	10	478		1,433	42
43	A/C Compressor replacement - Core Bldg	2016	14,255	1,426	10	1,426		3,386	43
44	A/C Compressor replacement - House 5	2016	6,504	650	10	650		1,545	44
45	A/C Compressor replacement - House 6	2016	6,529	653	10	653		1,496	45
46	Water Heater/120 Gal & Install	2017	3,020	579	5	579		1,158	46
47	Bathroom Faucets - House 2, 4, 5 & 6	2017	7,455	1,491	5	1,491		2,920	47
48	A/C Compressor replacement - House 4	2017	6,545	654	10	654		1,064	48
49	Emergency Generator Radiator	2017	6,673	334	10	334		695	49
50	Front door hardware - deposit	2017	1,529	204	15	204		280	50
51	Physical Therapy door & hardware - deposit	2017	2,117	94	15	94		94	51
52	Front door hardware	2018	178		15				52
53	Front Door Completion	2018	2,116		15				53
54	Heater Blower Replacement- House 7	2018	3,016	134	10	134		134	54
55	Heater Blower Replacement- House 4	2018	3,016	134	10	134		134	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)		\$ 4,319,861	\$ 148,509		\$ 148,509	\$	\$ 3,466,277	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	\$ 42,593	\$ 8,088	\$ 8,088	\$		\$ 33,011	71
72	Current Year Purchases	1,181	125	125			125	72
73	Fully Depreciated Assets	196,027					196,027	73
74								74
75	TOTALS	\$ 239,801	\$ 8,213	\$ 8,213	\$		\$ 229,163	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	\$ 49,735	\$	\$	\$		\$ 49,735	76
77	Patient Care	2012 Kia Sedona (2)	2011	42,190					42,190	77
78	Patient Care	2011 Dodge Wheelchair Vans	2011	82,057					82,057	78
79	Patient Care	2010 Dodge Grand Caravan	2016	14,107	2,822	2,822			7,407	79
80	TOTALS			\$ 188,089	\$ 2,822	\$ 2,822	\$		\$ 181,389	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)	\$ 4,747,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,544	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,544	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)	\$ 3,876,829	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 378 Description: Various

(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.

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

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

<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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		948		948
3	Classroom Wages (a)		20,724		20,724
4	Clinical Wages (b)		46,624		46,624
5	In-House Trainer Wages (c)		3,409		3,409
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 71,705	\$	\$ 71,705
10	SUM OF line 9, col. 1 and 2 (e)	\$	71,705		

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	78	\$ 3,900	\$	78	\$ 3,900	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		80	4,790		80	4,790	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-1 & 10a-3	1560 hrs	19,328	82	4,101		1,642	23,429	4
5	Physician Care		visits							5
6	Dental Care	10-3	visits		27	1,146		27	1,146	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$ 19,328	267	\$ 13,937	\$	1,827	\$ 33,265	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 and Friends of the Specialized Living Center

0026733

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(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	\$ 82,329	\$	1
2	Cash-Patient Deposits	3,782		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>26,009</u>)	327,065		3
4	Supply Inventory (priced at _____)	9,744		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,193		6
7	Other Prepaid Expenses	876		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 435,989	\$	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	4,312,076		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	435,675		16
17	Accumulated Depreciation (book methods)	(3,876,829)		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)	\$ 870,923	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,306,912	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 63,998	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	186,709		29
30	Accrued Salaries Payable	189,833		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,655		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	<u>Accrued Expenses</u>	19,568		36
37	<u>Other Liabilities</u>	294,605		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 766,368	\$	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)	\$ 766,368	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 540,544	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,306,912	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,053,425	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,053,425	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(512,881)	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)	\$ (512,881)	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)	\$ 540,544	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Parents and Friends of the Specialized Living Cente # 0026733 Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	\$ 3,247,909	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,247,909	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	71,705	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)	\$ 71,705	23
D. Non-Operating Revenue			
24	Contributions	8,059	24
25	Interest and Other Investment Income***	35	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,094	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	13,141	28
28a	Gain/Loss on Asset Disposal	(8,928)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,213	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,331,921	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	673,190	31
32	Health Care	2,087,579	32
33	General Administration	717,106	33
B. Capital Expense			
34	Ownership	162,343	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	204,584	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,844,802	40
41	Income before Income Taxes (line 30 minus line 40)**	(512,881)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (512,881)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,247,909	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,247,909	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 and Friends of the Specialized Living Center

0026733

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	2,064	2,252	\$ 81,318	\$ 36.11	1
2	Assistant Director of Nursing	7,345	8,013	98,805	12.33	2
3	Registered Nurses					3
4	Licensed Practical Nurses	17,227	18,794	411,424	21.89	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	1,560	1,702	19,328	11.36	7
8	Rehab/Therapy Aides	65,660	71,634	773,453	10.80	8
9	Activity Director	2,154	2,350	30,338	12.91	9
10	Activity Assistants	1,896	2,069	20,564	9.94	10
11	Social Service Workers	1,885	2,056	26,951	13.11	11
12	Dietician					12
13	Food Service Supervisor	1,798	1,962	26,870	13.70	13
14	Head Cook	2,660	2,902	38,804	13.37	14
15	Cook Helpers/Assistants	8,583	9,364	95,531	10.20	15
16	Dishwashers					16
17	Maintenance Workers	3,906	4,261	78,061	18.32	17
18	Housekeepers	3,050	3,327	42,890	12.89	18
19	Laundry					19
20	Administrator	1,866	2,036	42,258	20.76	20
21	Assistant Administrator					21
22	Other Administrative	4,380	4,779	92,604	19.38	22
23	Office Manager	869	948	27,554	29.07	23
24	Clerical	2,182	2,381	36,400	15.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,313	3,614	93,290	25.81	28
29	Resident Services Coordinator	10,325	11,264	137,994	12.25	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: OJT and Staff Tra	18,567	20,256	200,742	9.91	32
33	Other(specify) <u>Quality Assurance</u>	1,898	2,071	47,096	22.74	33
34	TOTAL (lines 1 - 33)	163,187	178,035	\$ 2,422,275 *	\$ 13.61	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	147	\$ 7,548	1-3	35
36	Medical Director	Monthly	20,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	82	4,101	10A-3	40
41	Occupational Therapy Consultant	78	3,900	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	80	4,790	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	35	2,100	11-3	45
46	Other(specify) <u>Psychiatrist</u>	51	5,200	10-3	46
47	<u>Psychologist</u>	341	24,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	814	\$ 72,039		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	211	7,713	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	211	\$ 7,713		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	
Frank Dicksonson	Administrator		\$ 42,258	Workers' Compensation Insurance	\$ 68,738	IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,048	Advertising: Employee Recruitment	499	
				FICA Taxes	180,028	Health Care Worker Background Check (Indicate # of checks performed 79)	790	
				Employee Health Insurance	69,964			
				Employee Meals	0	MES/HPSI Dues	233	
				Illinois Municipal Retirement Fund (IMRF)*		Professional Dues	2,500	
						Licensing	60	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 42,258	Employee Physicals	2,285	Marketing & Advertising	771	
B. Administrative - Other				Employee Life Insurance	857			
Description			Amount	403(b) Employer Contribution	572	Less: Public Relations Expense	(771)	
			\$	Disability Insurance	2,124	Non-allowable advertising	()	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 325,616		\$ 4,082	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount
Vendor/Payee	Type							
CLA	Accounting		\$ 65,315			\$	Out-of-State Travel	\$
Kennedy Hunt PC	Legal		2,000					
Polsinelli PC	Legal		2,391					
Evans Law Firm	Legal		5,957				In-State Travel	776
Kennedy Hunt PC	Legal		1,025					
Zane Zielinski PC	Legal		(403)				Seminar Expense	395
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 76,284	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,171

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parents and Friends of the Specialized Living Center# 0026733Report Period Beginning: 01/01/2018Ending: 12/31/2018**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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 65
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,409 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. \$ 204,584
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
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?
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: Scheffel Boyle
- (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