FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0026733

Facility Name: Parents & Friends of the SLC

Address: 1450 Caseyville Ave (Number) Swansea (City) 62226 (Zip Code)

County: St Clair

Telephone Number: (618) 277-7730 **Fax #** (618) 277-5423

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1982

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mary Ann Nold **Telephone Number:** (618) 277-7730 ext 3309
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Krystal Gruenenfelder
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	26,668			26,668	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,668			26,668	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.06%

D. How many bed-hold days during this year were paid by the Department?
276 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,943	13,557	8,698	201,198		201,198		201,198			1
2	Food Purchase		155,634		155,634		155,634		155,634			2
3	Housekeeping	35,437	13,675	8,498	57,610		57,610		57,610			3
4	Laundry		5,950		5,950		5,950		5,950			4
5	Heat and Other Utilities			111,634	111,634		111,634		111,634			5
6	Maintenance	64,091	14,420	23,504	102,015		102,015		102,015			6
7	Other (specify):*											7
8	**TOTAL General Services**	278,471	203,236	152,334	634,041		634,041		634,041			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,993,196	85,752	59,283	2,138,231		2,138,231		2,138,231			10
10a	Therapy	16,408		10,040	26,448		26,448		26,448			10a
11	Activities	43,364	9,650		53,014	800	53,814		53,814			11
12	Social Services	15,343		1,440	16,783		16,783		16,783			12
13	CNA Training	14,398			14,398		14,398		14,398			13
14	Program Transportation		10,872		10,872		10,872		10,872			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,082,709	106,274	87,563	2,276,546	800	2,277,346		2,277,346			16
	C. General Administration											
17	Administrative	52,042		1,801	53,843		53,843		53,843			17
18	Directors Fees											18
19	Professional Services			88,130	88,130		88,130	(3,000)	85,130			19
20	Dues, Fees, Subscriptions & Promotions			6,019	6,019	1,303	7,322	(2,072)	5,250			20
21	Clerical & General Office Expenses	119,538	9,360	32,199	161,097		161,097		161,097			21
22	Employee Benefits & Payroll Taxes			422,801	422,801	(1,303)	421,498		421,498			22
23	Inservice Training & Education			1,362	1,362		1,362		1,362			23
24	Travel and Seminar			125	125		125		125			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,813	79,813		79,813		79,813			26
27	Other (specify):*											27
28	**TOTAL General Administration**	171,580	9,360	632,250	813,190		813,190	(5,072)	808,118			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,532,760	318,870	872,147	3,723,777	800	3,724,577	(5,072)	3,719,505			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number: Parents & Friends of the SLC #0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			182,306	182,306		182,306		182,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9	9		9		9			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			920	920	(800)	120		120			36
37	**TOTAL Ownership**			183,235	183,235	(800)	182,435		182,435			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			243,552	243,552		243,552		243,552			42
43	Other (specify):* **Bad Ebts**			11,719	11,719		11,719	(11,719)				43
44	**TOTAL Special Cost Centers**			255,271	255,271		255,271	(11,719)	243,552			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,532,760	318,870	1,310,653	4,162,283		4,162,283	(16,791)	4,145,492			45

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,072)	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	(3,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,719)	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)**	$ (16,791)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,791)		37

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

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

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

Parents & Friends of the SLC

ID# 0026733

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line 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 # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	19
20	Fees, Subscriptions & Promotions	(2,072)	0	0	0	0	0	0	0	0	0	0	(2,072)	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**	(5,072)	0	0	0	0	0	0	0	0	0	0	(5,072)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,072)	0	0	0	0	0	0	0	0	0	0	(5,072)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parents & Friends of the SLC # 0026733 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	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):*	(11,719)	0	0	0	0	0	0	0	0	0	0	(11,719)	43
44	**TOTAL Special Cost Centers**	(11,719)	0	0	0	0	0	0	0	0	0	0	(11,719)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(16,791)	0	0	0	0	0	0	0	0	0	0	(16,791)	45

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	Gymnasium Rental	$ 800	SLC Enrichment Center		$ 800	$	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			$ 800			$ 800	$ *	14

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Central Bank		X	Line of Credit	Interest Only	8/23/2016	as needed	Zero	08/22/2017	0.0350	9	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 9	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 9	15

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.)**

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2016 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:		
2011		8
2012		9
2013		10
2014		11
2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents & Friends of the SLC 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick and Frame Frame Protected Non-Combu Number of Stories Single

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	42,317	1979	$ 999	1
2					2
3	TOTALS	42,317		$ 999	3

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1982	1982	$ 2,999,001	$ 100,000	30	$ 100,000	$	$ 2,390,888	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		19			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	3,722	15	3,722		39,393	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		2,716	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		9,541	19
20	Water heater/120 gal and install			2008	4,843		5			4,843	20
21	Door frams (6) (Overhead Door)			2008	3,296		7			3,296	21
22	Core Building Roof			2008	46,873	2,344	20	2,344		19,584	22
23	Replacement of fire alarm panel			2008	3,398	170	20	170		1,458	23
24	Replace 7.5 ton A/C unit (House 6)			2008	6,253	625	10	625		5,367	24
25	REPLACEMENTS House 3			2008	2,636	264	10	264		2,240	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		3,642	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		3,073	29
30	Freezer Floor			2009	11,536	1,153	10	1,153		8,363	30
31	Sprinkler System			2010	515,800	25,790	20	25,790		162,084	31
32	Fire alarm upgrade			2010	22,426	1,121	20	1,121		7,132	32
33	Core Building Roof Repairs			2010	3,212	160	5	160		1,057	33
34	Sidewalks			2010	21,075	2,108	10	2,108		15,193	34
35	Pod 2 Air Conditioner			2012	6,200	1,240	5	1,240		5,993	35
36	Painting in Houses			2013	4,361	872	5	872		3,271	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flooring in Houses	2013	$ 32,652	$ 2,177	15	$ 2,177	$	$ 8,163	37
38	Painting in Houses	2013	2,107	421	5	421		1,545	38
39	Electronic Doors - Core Building	2013	9,620	481	20	481		1,643	39
40	House 2 & 3 Door Replacement	2015	8,727	436	20	436		746	40
41	Lobby and small hall flooring	2015	2,646	265	10	265		430	41
42	Air Handler House 7	2016	4,986	478	10	478		478	42
43	A/C Compressor replacement - Core Bldg	2016	14,255	535	10	535		535	43
44	A/C Compressor replacement - House 5	2016	6,504	244	10	244		244	44
45	A/C Compressor replacement - House 6	2016	6,529	190	10	190		190	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)		$ 4,283,198	$ 146,955		$ 146,955	$	$ 3,167,234	70

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 56,096	$ 11,951	$ 11,951	$		$ 31,528	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	295,502	2,648	2,648			295,502	73
74								74
75	TOTALS	$ 351,598	$ 14,599	$ 14,599	$		$ 327,030	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	$ 64,739	$	$	$	5	$ 64,739	76
77	Patient Care	2012 Kia Sedona (2)	2011	42,190	6,680	6,680		5	42,190	77
78	Patient Care	2011 Dodge Wheelchair vans	2011	82,057	12,309	12,309		5	82,057	78
79	Patient Care	2010 Dodge Grand Caravan	2016	14,107	1,763	1,763		5	1,763	79
80	TOTALS			$ 203,093	$ 20,752	$ 20,752	$		$ 190,749	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)	$ 4,838,888	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,306	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 182,306	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)	$ 3,685,013	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 # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		450		450
3	Classroom Wages (a)		10,180		10,180
4	Clinical Wages (b)		22,660		22,660
5	In-House Trainer Wages (c)		730		730
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 34,020	$	$ 34,020
10	SUM OF line 9, col. 1 and 2 (e)	$ 34,020			

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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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	10(3)	71	visits	3,151				71	3,151	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				$ 3,151		$	$	71	$ 3,151	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 **#** 0026733 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 442,785	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,278)	276,693		3
4	Supply Inventory (priced at)	10,105		4
5	Short-Term Investments			5
6	Prepaid Insurance	44,242		6
7	Other Prepaid Expenses	5,340		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from ERC - Payroll	1,739		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 780,904	$	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	4,284,196		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	554,691		16
17	Accumulated Depreciation (book methods)	(3,685,013)		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)**	$ 1,153,875	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,934,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 152,950	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,867		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,973		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)**	$ 379,790	$	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)**	$ 379,790	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,554,989	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,934,779	$	48

***(See instructions.)**

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,013,564	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,013,564	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(458,575)	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)**	$ (458,575)	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)**	$ 1,554,989	24 *

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,644,572	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,644,572	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	34,020	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)**	$ 34,020	23
	D. Non-Operating Revenue		
24	Contributions	1,365	24
25	Interest and Other Investment Income***	1,331	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,696	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	8,985	27
28	Garnishment Fees	475	28
28a	Gain on disposal of vehicles	12,960	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,420	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,703,708	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	634,041	31
32	Health Care	2,276,546	32
33	General Administration	813,190	33
	B. Capital Expense		
34	Ownership	183,235	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	243,552	36
	D. Other Expenses (specify):		
37	Bad Debts	11,719	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,162,283	40
41	**Income before Income Taxes (line 30 minus line 40)****	(458,575)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (458,575)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,055,739	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Cost of Care	569,310	47
48	Other-(specify) Work Recoupment	19,523	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,644,572	49

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

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

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

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

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,831	2,003	$ 55,610	$ 27.76	1
2	Assistant Director of Nursing	1,834	2,142	44,817	20.92	2
3	Registered Nurses					3
4	Licensed Practical Nurses	16,255	17,599	310,068	17.62	4
5	CNAs & Orderlies					5
6	CNA Trainees	8,779	9,173	85,431	9.31	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,374	1,651	16,990	10.29	8
9	Activity Director	1,635	1,848	20,491	11.09	9
10	Activity Assistants	2,398	2,539	22,543	8.88	10
11	Social Service Workers	1,111	1,220	14,866	12.19	11
12	Dietician					12
13	Food Service Supervisor	1,910	2,125	27,998	13.18	13
14	Head Cook	4,291	5,473	61,041	11.15	14
15	Cook Helpers/Assistants	8,603	9,116	88,140	9.67	15
16	Dishwashers					16
17	Maintenance Workers	4,035	4,493	66,867	14.88	17
18	Housekeepers	3,123	3,447	35,557	10.32	18
19	Laundry					19
20	Administrator	1,905	2,162	51,981	24.04	20
21	Assistant Administrator					21
22	Other Administrative	3,415	3,942	63,757	16.17	22
23	Office Manager	1,242	1,287	28,663	22.27	23
24	Clerical	1,868	2,082	24,296	11.67	24
25	Vocational Instruction					25
26	Academic Instruction	558	626	12,071	19.28	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,163	9,875	156,400	15.84	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	106,247	114,283	1,220,953	10.68	30
31	Medical Records					31
32	Other Health C: AOD	8,741	9,404	124,220	13.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,318	206,490	$ 2,532,760 *	$ 12.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	124	$ 6,244	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	30	1,588	10a, col 3	40
41	Occupational Therapy Consultant	66	3,287	10a, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	85	5,165	10a, col 3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,440	12, col 3	45
46	Other(specify) Psychiatrist	48	4,800	10, col 3	46
47	Psychologist	342	24,000	10, col 3	47
48					48
49	TOTAL (lines 35 - 48)	843	$ 64,524		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	754	26,132	10, col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	754	$ 26,132		53

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Krystal Gruenenfelder	Administrator	0	$ 52,042
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,042

B. Administrative - Other

Description	Amount
Bank Fees	$ 1,761
Late Fees	40
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,801
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen	Accounting Service	$ 52,450
ScheffelBoyle	Financial Audit Service	9,475
Lowenbaum Partnership	Legal Services	3,131
Evans Law Firm	Legal Services	74
Law Office of Keith Short	Claim Settlement	6,667
Law Office of Zane Zielinski	Legal Services	3,000
Dana Kolb	Claim Settlement	13,333
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 88,130

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 124,437
Unemployment Compensation Insurance	7,786
FICA Taxes	191,011
Employee Health Insurance	76,911
Employee Meals	16,380
Illinois Municipal Retirement Fund (IMRF)*	702
Employee Gifts	350
Employee Physicals	310
Employee Life and Disability Insurance	3,611
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,498

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	189
Health Care Worker Background Check	
(Indicate # of checks performed 41)	1,303
Patient Background Checks	
Licensing fees	125
MES/HPSI Dues	175
IL Health Care Assoc dues	3,428
Marketing - Brochure	30
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,250

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
IL Health Care ID/DD Symposium	125
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 125

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parents & Friends of the SLC # 0026733 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 $5,500**

(3) Did the nursing home make political contributions or payments to a politica
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? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **27,736** 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 fo
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 Departmen
during this cost report period. $ **243,552**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **16,380** 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 fo
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
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 Sprecialized Living Center
IDPH # 0026773
Cost Report Attachment 1
Schedule V Reclassifications

Schedule V Reclassifications			Description
Activity Other	$	800	Gym rental fee
Dues/Subscriptions	$	1,303	Employee background checks
Employee benefits	$	(1,303)	Employee background checks
Ownership - Other	$	(800)	Gym rental fee
Net Adjustments	$	-	

Parents and Friends of the Sprecialized Living Center
IDPH # 0026773
Cost Report Attachment 2
Page 19 Supplementary Schedule

Line 25 - Interest and Other Investment Income

Bank Interest - Unrestricted	$ 1,331

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

Line 23 - In-service Training and Education

CPR Cards for employees	171
Food Handler Training and Food Sanitation courses	179
Illinois Summit	56
Handbook for Hospital billing	29
Tech Support training - new IDPA software	927
Total	$ 1,362

Line 24 - Travel and Seminar	Total	Registration	Hotel	Fuel and Meals
IHCA ID/DD Symposium	125	125		
Total	$ 125	$ 125	$ -	$ -

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

Invoice Date	Allowable Amount	Nonallowable Amount	Description of Services
Lowenbaum Partnership			
1/31/2016	66	-	FMLA IDHR Employee issue
2/29/2016	88	-	FMLA IDHR Employee issue
2/29/2016	1,309	-	FMLA IDHR Employee issue
3/31/2016	75	-	Audit confirmation response
4/1/2016	1,268	-	FMLA IDHR Employee issue
4/30/2016	66	-	FMLA IDHR Employee issue
6/1/2016	21	-	FMLA IDHR Employee issue
9/30/2016	238	-	Employment law matter
	3,131	-	
Evans Law Firm			
4/5/2016	74	-	Resident safety matter
	74	-	
The Law Office of Zane Zielinski			
12/14/2016	3,000	3,000	Retainer for Passages Hospice collection efforts
	3,000	3,000	