

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0026773

Facility Name: Parents and Friends of the Specialized Living Center

Address: 1450 Caseyville Avenue Swansea 62226

County: St. Clair

Telephone Number: 618-277-7730 Fax #: 618-277-5423

HFS ID Number:

Date of Initial License for Current Owners: 01/01/82

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501c-3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Jana Heuer 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 01/01/11 to 12/31/11 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)

(Type or Print Name) Karene Dotson

(Title) Administrator

Paid Preparer

(Signed)

(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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,690			35,690	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,690			35,690	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.78%

D. How many bed-hold days during this year were paid by the Department? 254 (Do not include bed-hold days in Section B.)

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

N/A

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	212,186	17,470	7,140	236,796		236,796		236,796			1
2	Food Purchase		141,825		141,825		141,825		141,825			2
3	Housekeeping	39,071	21,054	7,096	67,221		67,221		67,221			3
4	Laundry		2,828		2,828		2,828		2,828			4
5	Heat and Other Utilities			135,165	135,165		135,165		135,165			5
6	Maintenance	52,619	8,676	19,250	80,545		80,545		80,545			6
7	Other (specify):*											7
8	TOTAL General Services	303,876	191,853	168,651	664,380		664,380		664,380			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,396,938	71,649	79,339	2,547,926	(144)	2,547,782		2,547,782			10
10a	Therapy	20,326			20,326		20,326		20,326			10a
11	Activities	57,732	12,699		70,431	2,368	72,799		72,799			11
12	Social Services	19,796		1,590	21,386		21,386		21,386			12
13	CNA Training	11,883			11,883		11,883		11,883			13
14	Program Transportation		19,675		19,675		19,675		19,675			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,506,675	104,023	80,929	2,691,627	2,224	2,693,851		2,693,851			16
	C. General Administration											
17	Administrative	46,465		1,802	48,267	(1,644)	46,623		46,623			17
18	Directors Fees											18
19	Professional Services			(9,849)	(9,849)		(9,849)		(9,849)			19
20	Dues, Fees, Subscriptions & Promotions			6,716	6,716	1,416	8,132	(2,048)	6,084			20
21	Clerical & General Office Expenses	133,813	21,961	20,094	175,868		175,868		175,868			21
22	Employee Benefits & Payroll Taxes			621,620	621,620	(1,240)	620,380		620,380			22
23	Inservice Training & Education			3,675	3,675		3,675		3,675			23
24	Travel and Seminar			2,135	2,135		2,135		2,135			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,339	62,339		62,339		62,339			26
27	Other (specify):*											27
28	TOTAL General Administration	180,278	21,961	708,532	910,771	(1,468)	909,303	(2,048)	907,255			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,990,829	317,837	958,112	4,266,778	756	4,267,534	(2,048)	4,265,486			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			225,915	225,915		225,915		225,915			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					1,644	1,644		1,644			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			22,400	22,400	(2,400)	20,000	(20,000)				36
37	TOTAL Ownership			248,315	248,315	(756)	247,559	(20,000)	227,559			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			268,119	268,119		268,119		268,119			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			268,119	268,119		268,119		268,119			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,990,829	317,837	1,474,546	4,783,212		4,783,212	(22,048)	4,761,164			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(2,048)	20		17
18	Fines and Penalties	(20,000)	36		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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)	\$ (22,048)		\$	30

BHF USE ONLY							
48		49		50		51	

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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (22,048)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID#0026773

Report Period Beginning:01/01/11

Ending:12/31/11

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 and Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,048)	0	0	0	0	0	0	0	0	0	0	(2,048)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,048)	0	0	0	0	0	0	0	0	0	0	(2,048)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,048)	0	0	0	0	0	0	0	0	0	0	(2,048)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parents and Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(20,000)	0	0	0	0	0	0	0	0	0	0	(20,000)	36
37	TOTAL Ownership	(20,000)	0	0	0	0	0	0	0	0	0	0	(20,000)	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)	(22,048)	0	0	0	0	0	0	0	0	0	0	(22,048)	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.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1Schedule V		2Line	3Cost Per General Ledger	4Amount	5Cost to Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$		1
2	V		Gymnasium Rental	2,400	SLC Enrichment Center		2,400		2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,400			\$ 2,400	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents and Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Community First Bank		X	Real Estate Mortgage	\$3,284.00	10/15/10	\$ 299,087	\$		0.0575	\$ 1,138	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Community First Bank		X	Line of Credit	Interest Only	03/15/11	as needed	493,500		0.0525	506	6
7												7
8												8
9	TOTAL Facility Related				\$3,284.00		\$ 299,087	\$ 493,500			\$ 1,644	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 299,087	\$ 493,500			\$ 1,644	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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 2010 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 2011 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:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0026773

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 42,317
- B. General Construction Type: Exterior Brick and frameFrame Protected non combustNumber of Stories single
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100		1982	1982	\$ 2,999,001	\$ 100,000	30	\$ 100,000		\$ 1,889,315	4
5			1984	1884	303,400	10,113	30	10,113		273,907	5
6			1984	1984	33,537		15			33,537	6
7											7
8											8
	Improvement Type**										
9	Doors - ERC			1985	564	19	30	19		495	9
10	Gynamsium Roof			2000	21,635	1,442	15	1,442		15,986	10
11	Fires Supression System (Dietary{			2003	2,740		7			2,740	11
12	Water Centers			2004	1,960		7			1,960	12
13	United Refridgeration			2004	742	53	7	53		742	13
14	Belo Sales and service			2004	4,261	355	7	355		4,261	14
15	Belo - Sales and Service			2004	14,839	1,237	7	1,237		14,839	15
16	Cabinets in House 3			2006	812	81	10	81		480	16
17	Flooring in Houses and Nurses Office			2006	55,833	3,722	15	3,722		20,782	17
18	Carpet Squares/ Houses living room			2006	2,298	192	5	192		2,298	18
19	Fire Alarm Control Panel			2007	5,431	271	20	271		1,358	19
20	Painting of 2 Houses			2007	16,600	3,320	5	3,320		13,833	20
21	Painting of 2 Houses			2007	16,600	3,320	5	3,320		13,833	21
22	Painting of 2 Houses			2007	16,600	3,320	5	3,320		13,833	22
23	Blinds in Houses			2008	10,700	1,070	10	1,070		4,190	23
24	Water heater			2008	4,843	969	5	969		3,713	24
25	Door frames			2008	3,296	471	7	471		1,660	25
26	Core Building Roof			2008	46,873	2,344	20	2,344		7,866	26
27	Clean out in Kitchen			2008	1,950	195	10	195		699	27
28	Motor of A/C unit			2008	914	91	10	91		328	28
29	replacement of fire alarm Panel			2008	3,398	170	20	170		609	29
30	replace 7.5 ton A/C Unit			2008	6,253	625	10	625		2,241	30
31	A.C replacements House 3			2008	2,636	263	10	263		922	31
32	Booster Water Heater (House 5)			2008	2,953	591	5	591		1,821	32
33	Squirrel Cage for House 6			2008	4,370	437	10	437		1,457	33
34	Renovation of Pod 2			2001	68,477					68,477	34
35	Roof Repairs Houses 2,4,5,&6			2008	24,968	4,994	5	4,994		15,813	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XL OWNERSHIP COSTS (continued)

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

1	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 Starter Assemblies 2,4,5&6	2008	\$ 3801.94	\$ 380	10	\$ 380	\$	\$ 1,172	37
38 Condenser Motor in Core Bldg A/C	2008	1517.47	152	10	152		468	38
39 Smoke Detector Installation	2008	1433	143	10	143		442	39
40 Sprinkler System	2009	6000	300	20	300		750	40
41 Freezer Floor	2009	11535.6	1,153	10	1,153		2,596	41
42 Sprinkler System	2010	532226	26,611	20	26,611		35,482	42
43 Core Building Roof Repairs	2010	3212	161	5	161		254	43
44 Pod 4 Kitchen	2010	2016.13	202	10	202		320	44
45 Sidewalks (Architech Fee)	2010	2860	286	10	286		405	45
46 Sidewalks	2010	18216	3,643	10	3,643		4,250	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)		\$ 4,261,302	\$ 172,696		\$ 172,696	\$	\$ 2,460,134	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$200,348	\$32,351	\$32,351	\$		\$138,202	71
72	Current Year Purchases	15,634	1,712	1,712			1,712	72
73	Fully Depreciated Assets	47,186	2,048	2,048			47,186	73
74								74
75	TOTALS	\$263,168	\$36,111	\$36,111	\$		\$187,100	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	various	various	\$39,881	\$1,561	\$1,561	\$	5	\$39,881	76
77	Patient Care	Dodge Caravan Van	2006	39,405	7,224	7,224		5	39,405	77
78	Patient Care	Kia Sadonas (#3)	2011	63,285	4,219	4,219		5	4,219	78
79	Patient Care	Wheelchair vans (#2)	2011	82,057	4,103	4,103		5	4,103	79
80	TOTALS			\$224,628	\$17,107	\$17,107	\$		\$87,608	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$4,750,09781
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$225,91482
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$225,91483
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)	\$2,734,84285

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: 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:
- *

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2012\$
13. /2013\$
14. /2014\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ 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☒
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA90

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		950		950
3	Classroom Wages (a)		1,520		1,520
4	Clinical Wages (b)		39,334		39,334
5	In-House Trainer Wages (c)		2,526		2,526
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 44,330	\$	\$ 44,330
10	SUM OF line 9, col. 1 and 2 (e)	\$ 44,330			

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.
SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	Line 10/Column 3	125 visits	6,340				125	6,340	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			\$ 6,340		\$	\$	125	\$ 6,340	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$227,123	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,649,336		3
4	Supply Inventory (priced at)	8,411		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	53,272		7
8	Accounts Receivable (owners or related parties)	2,387		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$2,940,529	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,262,301		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	487,796		16
17	Accumulated Depreciation (book methods)	(2,734,842)		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)	\$2,015,255	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$4,955,784	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$893,492	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	493,500		29
30	Accrued Salaries Payable	310,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,956		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)	\$1,721,486	\$	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)	\$1,721,486	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$3,234,298	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$4,955,784	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,122,049	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,122,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	112,249	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)	\$ 112,249	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)	\$ 3,234,298	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents and Friends of the Specialized Living Centre # 0026773 Report Period Beginning: 01/01/11Ending: 12/31/11**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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,840,421	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,840,421	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	44,330	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)	\$ 44,330	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,438	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,438	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Garnishment Service Charges</u>	1,272	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,272	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,895,461	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	686,780	31
32	Health Care	2,691,627	32
33	General Administration	910,771	33
	B. Capital Expense		
34	Ownership	225,915	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	268,119	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,783,212	40
41	Income before Income Taxes (line 30 minus line 40)**	112,249	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 112,249	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

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	875	967	\$ 22,722	\$ 23.50	1
2	Assistant Director of Nursing	1,773	2,070	38,364	18.53	2
3	Registered Nurses	671	760	16,290	21.43	3
4	Licensed Practical Nurses	16,948	18,387	329,587	17.93	4
5	CNAs & Orderlies					5
6	CNA Trainees	10,855	10,855	89,635	8.26	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,788	1,998	20,326	10.17	8
9	Activity Director	1,000	1,100	20,083	18.26	9
10	Activity Assistants	3,808	4,053	37,650	9.29	10
11	Social Service Workers	1,000	1,085	19,796	18.25	11
12	Dietician					12
13	Food Service Supervisor	3,245	3,671	49,385	13.45	13
14	Head Cook	5,188	5,591	60,192	10.77	14
15	Cook Helpers/Assistants					15
16	Dishwashers	10,684	11,341	102,609	9.05	16
17	Maintenance Workers	3,716	4,173	52,619	12.61	17
18	Housekeepers	3,649	3,945	39,071	9.90	18
19	Laundry					19
20	Administrator	1,688	1,892	46,465	24.56	20
21	Assistant Administrator					21
22	Other Administrative	3,084	3,583	69,235	19.32	22
23	Office Manager	1,214	1,400	29,770	21.26	23
24	Clerical	1,846	2,080	24,335	11.70	24
25	Vocational Instruction					25
26	Academic Instruction	583	621	11,883	19.14	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,247	9,310	168,590	18.11	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	146,004	157,538	1,573,449	9.99	30
31	Medical Records					31
32	Other Health Care(specify)	10,718	11,920	158,033	13.26	32
33	Other(specify) <u>Seamstress</u>	1,137	1,269	10,740	8.46	33
34	TOTAL (lines 1 - 33)	239,721	259,609	\$ 2,990,829 *	\$ 11.52	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	153	\$ 7,140	line 1, c 3	35
36	Medical Director	112	16,800	Line 10, c 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	Line 10, c 3	39
40	Physical Therapy Consultant	34	1,688	Line 10, c 3	40
41	Occupational Therapy Consultant	160	7,975	Line 10, c 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	99	5,910	Line 10, c 3	43
44	Activity Consultant				44
45	Social Service Consultant	27	1,590	Line 12, c3	45
46	Other(specify) <u>Psychologist</u>	300	19,788	Line 10, c 3	46
47	<u>Psychiatrist</u>	38	3,780	Line 10, c 3	47
48					48
49	TOTAL (lines 35 - 48)	935	\$ 65,871		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	453	15,858	Line 10, c 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	453	\$ 15,858		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Karlene Dotson	Administrator	0	\$ 46,465
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 46,465
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Evans Law Firm	Legal		\$ 1,608
Duane Morris, LLP	Legal - credit issued		(27,248)
SIDC Payroll Services	Payroll Services		5,027
Clifton Larson Allen, LLC	Financial Audit Services		10,764
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ (9,849)
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 57,445
Unemployment Compensation Insurance			22,782
FICA Taxes			220,299
Employee Health Insurance			206,598
Employee Meals			96,839
Illinois Municipal Retirement Fund (IMRF)*			
Employee Physicals			2,225
Employee Gift/Relations			3,994
Employer Matching 403B Contribution			1,131
Employee Life & Disability Insurance			9,067
TOTAL (agree to Schedule V, line 22, col.8)			\$ 620,380
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			444
Health Care Worker Background Check (Indicate # of checks performed 62)			1,240
Patient Background Checks 11			176
Illinois Health Care Association Dues			3,390
Licensing Fees			449
HPSI dues			175
SAM's Club Membership			210
Less: Public Relations Expense			()
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,084
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			3,675
Seminar Expense			
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 3,675

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

Illinois Health Care Association - \$3,390

(3) Did the nursing home make political contributions or payments to a political action organization?

no

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$

33,737

 Line

10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES

NO

X

 If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$

268,119

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. \$

96,839

 Has any meal income been offset against related costs?

no

 Indicate the amount. \$(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

 If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

99%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

n/a

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period. \$

n/a

(17) Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name:

Clifton Larson Allen LLC

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

**Parents & Friends of the SLC
Cost Report Attachment I
Schedule XI
Capital Rate Increase Request**

In accordance with Title 89 III Admin. Code 140.579 Parents and Friends of the SLC is requesting a capital rate increase due to a major capital improvement mandated by the State of Illinois.

In 2010, the construction of a Sprinkler System at our facility was completed. The total cost of this system was \$538,226.

Parents and Friends of the SLC
Cost Report Attachment 2
Schedule V Line 23 & 24

Line 23 - Inservice Training & Education

American Red Cross Rentals	2,675
Food Sanitation Course Instructor Fee	1,000

Total Line 23	<u><u>3,675</u></u>
---------------	---------------------

Line 24 - Travel & Seminar

	<u>Date</u>	<u>Registration Fee</u>	<u>Hotel</u>	<u>Gasoline</u>	<u>Meals</u>	<u>Total</u>
IDMA Workshop	Jan. 7, 2010	75	77			152
IHCA Convention & Trade Show	Sept. 13-15, 20	915	1,068	-	-	1,983
Total Line 24						<u><u>2,135</u></u>

Parents and Friends of the SLC
Cost Report Attachment 3
Schedule V Reclassifications

Schedule V Reclassifications		Description
Nursing Supplies	(144)	Patient Background checks
Activity Other	2,368	+2,400 Gym Rental Fee/ -32 Patient Background checks
Administrative Other	(1,644)	Interest expense
Dues/Subscriptions	1,416	+1,240 Employee Backgroup Checks/+176 Patient Background checks
Employee Benefits	(1,240)	-1,240 Employee Background Checks/-32 Patient Background checks
Interest	1,644	Interest expense
Other	(2,400)	-2,400 Gym Rental Fee
Net Adjustments		-

Parents and Friends of the Specialized Living Center
Cost Report Attachment 4
SCHEDULE XVIII, Line32

Line 32 Other Health Care = Administrators on Duty

Parents and Friends of the Specialized Living Center
Cost Report Attachment 5
IDPHID# 0026773
01/01/11 - 12/31/11

Board Members:

Orville Lester
Edward Nida
Arland Lester
Donna Harris
Wilma Postin
Agnes Schloeman
Gwen Stauder

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