		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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 & Friends of the Specialized Living Center

Address: 1450 Caseyville Avenue (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: 01/01/82

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C-3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/10 to 12/31/10 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) 03/28/11 (Date)
(Type or Print Name) Karlene Dotson
(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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 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	34,922			34,922	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,922			34,922	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.68%

D. How many bed-hold days during this year were paid by the Department?
251 (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)

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

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: 01/01/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living C # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	214,280	15,704	7,853	237,837		237,837		237,837			1
2	Food Purchase		154,219		154,219		154,219		154,219			2
3	Housekeeping	44,093	21,627	11,202	76,922		76,922		76,922			3
4	Laundry		4,653		4,653		4,653		4,653			4
5	Heat and Other Utilities			150,793	150,793		150,793		150,793			5
6	Maintenance	73,816	16,783	19,976	110,575		110,575		110,575			6
7	Other (specify):*											7
8	TOTAL General Services	332,189	212,986	189,824	734,999		734,999		734,999			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,402,815	69,242	78,763	2,550,820	(43)	2,550,777		2,550,777			10
10a	Therapy	20,700			20,700		20,700		20,700			10a
11	Activities	46,616	11,637		58,253	2,400	60,653	(296)	60,357			11
12	Social Services	27,329		1,755	29,084		29,084		29,084			12
13	CNA Training	11,277			11,277		11,277		11,277			13
14	Program Transportation		15,431		15,431		15,431		15,431			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,508,737	96,310	80,518	2,685,565	2,357	2,687,922	(296)	2,687,626			16
	C. General Administration											
17	Administrative	45,291		19,995	65,286	(19,694)	45,592		45,592			17
18	Directors Fees											18
19	Professional Services			116,663	116,663		116,663		116,663			19
20	Dues, Fees, Subscriptions & Promotions			7,818	7,818	1,119	8,937	(1,705)	7,232			20
21	Clerical & General Office Expenses	149,640	10,956	21,672	182,268	109	182,377		182,377			21
22	Employee Benefits & Payroll Taxes			660,676	660,676	(1,076)	659,600		659,600			22
23	Inservice Training & Education			3,456	3,456		3,456		3,456			23
24	Travel and Seminar			3,011	3,011		3,011		3,011			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			59,966	59,966		59,966		59,966			26
27	Other (specify):*											27
28	TOTAL General Administration	194,931	10,956	893,257	1,099,144	(19,542)	1,079,602	(1,705)	1,077,897			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,035,857	320,252	1,163,599	4,519,708	(17,185)	4,502,523	(2,001)	4,500,522			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.

Facility Name & ID Number Parents & Friends of the Specialized Living Center #0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			201,044	201,044		201,044		201,044			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					19,694	19,694		19,694			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			52,909	52,909	(2,509)	50,400	(50,400)				36
37	**TOTAL Ownership**			253,953	253,953	17,185	271,138	(50,400)	220,738			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			257,768	257,768		257,768		257,768			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			257,768	257,768		257,768		257,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,035,857	320,252	1,675,320	5,031,429		5,031,429	(52,401)	4,979,028			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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(1,705)	20		17
18	Fines and Penalties	(50,400)	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)	$ (52,105)		$	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)	(296)	11	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (296)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (52,401)		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

Parents & Friends of the Specialized Living Center

ID# 0026773

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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 Specialized Living Center **#** 0026773 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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	(296)	0	0	0	0	0	0	0	0	0	0	(296)	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**	(296)	0	0	0	0	0	0	0	0	0	0	(296)	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	(1,705)	0	0	0	0	0	0	0	0	0	0	(1,705)	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**	(1,705)	0	0	0	0	0	0	0	0	0	0	(1,705)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,001)	0	0	0	0	0	0	0	0	0	0	(2,001)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
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):*	(50,400)	0	0	0	0	0	0	0	0	0	0	(50,400)	36
37	**TOTAL Ownership**	(50,400)	0	0	0	0	0	0	0	0	0	0	(50,400)	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)**	(52,401)	0	0	0	0	0	0	0	0	0	0	(52,401)	45

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Parents and Friends of the CIS	Belleville	SLC Enrichment	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. [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			Gymnasium Rental	$ 2,400	SLC Enrichment Center	N/A	$ 2,104	$ (296)	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 2,400			$ 2,104	$ * (296)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living (# 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living C # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Community First Bank		X	Construction Line	interest only	06/15/09	$ 271,211	$	10/15/10	0.0500	$ 16,632	1
2	Community First Bank		X	Real Estate Mortgage	$3,284.00	10/15/10	299,087	295,394	10/15/13	0.0575	2,922	2
3												3
4												4
5												5
	Working Capital											
6	Community First Bank		X	Line of Credit	interest only	03/15/10	as needed		03/15/11	0.0525	140	6
7												7
8												8
9	TOTAL Facility Related				$3,284.00		$ 570,298	$ 295,394			$ 19,694	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 570,298	$ 295,394			$ 19,694	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents & 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 2009 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 2009.

	(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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick and frame Frame Protected non combust 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		1979	$ 999	1
2					2
3	TOTALS			$ 999	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	$ 3,000,000	$ 100,000	30	$ 100,000	$	$ 1,789,315	4
5			1984	1884	303,400	10,133	30	10,133		263,794	5
6			1984	1984	33,537		15			33,537	6
7											7
8											8
	Improvement Type**										
9	Doors - ERC			1985	564	19	30	19		476	9
10	Gynamsium Roof			2000	21,635	1,442	15	1,442		14,544	10
11	Fires Supression System (Dietary{			2003	2,740		7			2,740	11
12	Water Centers			2004	1,960	280	7	280		1,960	12
13	United Refridgeration			2004	742	106	7	106		689	13
14	Belo Sales and service			2004	4,261	609	7	609		3,906	14
15	Belo - Sales and Service			2004	14,839	2,120	7	2,120		13,602	15
16	Cabinets in House 3			2006	812	81	10	81		399	16
17	Flooring in Houses and Nurses Office			2006	55,833	3,722	15	3,722		17,060	17
18	Carpet Squares/ Houses living room			2006	2,298	460	5	460		2,107	18
19	Fire Alarm Control Panel			2007	5,431	272	20	272		1,086	19
20	Painting of 2 Houses			2007	16,600	3,320	5	3,320		10,513	20
21	Painting of 2 Houses			2007	16,600	3,320	5	3,320		10,513	21
22	Painting of 2 Houses			2007	16,600	3,320	5	3,320		10,513	22
23	Blinds in Houses			2008	10,700	1,070	10	1,070		3,121	23
24	Water heater			2008	4,843	969	5	969		2,745	24
25	Door frames			2008	3,296	471	7	471		1,189	25
26	Core Building Roof			2008	46,873	2,344	20	2,344		5,522	26
27	Clean out in Kitchen			2008	1,950	195	10	195		504	27
28	Motor of A/C unit			2008	914	91	10	91		236	28
29	replacement of fire alarm Panel			2008	3,398	170	20	170		439	29
30	replace 7.5 ton A/C Unit			2008	6,253	625	10	625		1,615	30
31	A.C replacements House 3			2008	2,636	264	10	264		659	31
32	Booster Water Heater (House 5)			2008	2,953	591	5	591		1,230	32
33	Squirrel Cage for House 6			2008	4,370	437	10	437		1,020	33
34	Renovation of Pod 2			2001	68,476					68,476	34
35	Roof Repairs Houses 2,4,5,&6			2008	24,968	4,994	5	4,994		10,819	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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Starter Assemblies 2,4,5&6	2008	$ 3,802	$ 380	10	$ 380	$	$ 792	37
38	Condenser Motor in Core Bldg A/C	2008	1,517	152	10	152		316	38
39	Smoke Detector Installation	2008	1,433	143	10	143		299	39
40	Sprinkler System	2009	6,000	300	20	300		450	40
41	Freezer Floor	2009	11,536	1,154	10	1,154		1,442	41
42	Sprinkler System	2010	532,226	8,870	20	8,870		8,870	42
43	Core Building Roof Repairs	2010	3,212	94	5	94		94	43
44	Pod 4 Kitchen	2010	2,016	118	10	118		118	44
45	Sidewalks (Architecht Fee)	2010	2,860	119	10	119		119	45
46	Sidewalks	2010	18,216	607	10	607		607	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)		$ 4,262,300	$ 153,360		$ 153,360	$	$ 2,287,437	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 192,262	$ 31,599	$ 31,599	$		$ 115,064	71
72	Current Year Purchases	19,860	2,937	2,937		5	2,937	72
73	Fully Depreciated Assets	32,988	2,779	2,779		5	32,988	73
74								74
75	TOTALS	$ 245,110	$ 37,316	$ 37,316	$		$ 150,989	75

D. Vehicle Depreciation (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 - Fully Depr.	various	various	$ 59,677	$ 440	$ 440	$	5	$ 59,677	76
77	Patient Care	Dodge Ram 2500 Van	2006	8,645	1,729	1,729		5	7,348	77
78	Patient Care	Dodge Caravan Van	2006	39,405	7,881	7,881		5	32,181	78
79	Patient Care	Lap Belts	2007	1,589	318	318	0	5	1,213	79
80	TOTALS			$ 109,317	$ 10,368	$ 10,368	$ 0		$ 100,419	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)	$	4,617,726	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	201,044	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	201,044	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,538,845	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.	/2011	$
13.	/2012	$
14.	/2013	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		650		650
3	Classroom Wages (a)		8,428		8,428
4	Clinical Wages (b)		18,963		18,963
5	In-House Trainer Wages (c)		1,145		1,145
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 29,186	$	$ 29,186
10	SUM OF line 9, col. 1 and 2 (e)	$ 29,186			

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	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	26

(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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Line 10/Column 3	125	visits	6,324				125	6,324	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				$ 6,324		$	$	125	$ 6,324	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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 1,732,123	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	429,759		3
4	Supply Inventory (priced at)	8,861		4
5	Short-Term Investments			5
6	Prepaid Insurance	46,689		6
7	Other Prepaid Expenses	4,814		7
8	Accounts Receivable (owners or related parties)	29,975		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,252,221	$	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	354,426		16
17	Accumulated Depreciation (book methods)	(2,538,846)		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)**	$ 2,077,881	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,330,102	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 584,173	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	305,078		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,408		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)**	$ 912,659	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	295,394		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)**	$ 295,394	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,208,053	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,122,049	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,330,102	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,319,597	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,319,597	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,548)	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)**	$ (197,548)	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)**	$ 3,122,049	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,733,188	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,733,188	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	29,186	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)**	$ 29,186	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	69,396	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69,396	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	GARNISHMENT SERVICE CHARGES	2,111	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,111	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,833,881	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	734,999	31
32	Health Care	2,685,565	32
33	General Administration	1,099,144	33
	B. Capital Expense		
34	Ownership	253,953	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	257,768	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,031,429	40
41	**Income before Income Taxes (line 30 minus line 40)****	(197,548)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (197,548)	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.**

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,151	1,391	$ 38,240	$ 27.49	1
2	Assistant Director of Nursing	1,640	1,792	37,159	20.74	2
3	Registered Nurses					3
4	Licensed Practical Nurses	18,172	19,903	342,928	17.23	4
5	CNAs & Orderlies					5
6	CNA Trainees	10,802	10,802	91,082	8.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,822	2,042	20,698	10.14	8
9	Activity Director	1,927	2,120	29,727	14.02	9
10	Activity Assistants	1,505	1,703	15,902	9.34	10
11	Social Service Workers	1,786	2,005	29,173	14.55	11
12	Dietician					12
13	Food Service Supervisor	3,375	4,020	57,674	14.35	13
14	Head Cook	5,043	5,444	55,438	10.18	14
15	Cook Helpers/Assistants					15
16	Dishwashers	10,755	11,609	103,742	8.94	16
17	Maintenance Workers	5,209	5,792	76,275	13.17	17
18	Housekeepers	3,904	4,492	48,118	10.71	18
19	Laundry					19
20	Administrator	1,719	1,906	49,539	25.99	20
21	Assistant Administrator					21
22	Other Administrative	3,648	4,225	83,834	19.84	22
23	Office Manager	1,534	1,900	41,380	21.78	23
24	Clerical	1,929	2,140	24,414	11.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,175	10,174	162,932	16.01	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	153,817	166,243	1,704,980	10.26	30
31	Medical Records					31
32	Other Health Ca Training Coordina	598	621	11,671	18.79	32
33	Other(specify) Seamstress	1,188	1,276	10,951	8.58	33
34	TOTAL (lines 1 - 33)	240,699	261,600	$ 3,035,857 *	$ 11.60	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	171	$ 7,853	line 1, c3	35
36	Medical Director	99	15,008	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	32	1,600	line 10, c 3	40
41	Occupational Therapy Consultant	109	5,450	line 10, c 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	90	5,400	line 10, c 3	43
44	Activity Consultant				44
45	Social Service Consultant	29	1,755	line 21, c 3	45
46	Other(specify) Psychologist	300	19,788	line 10, c 3	46
47	Psychiatrist	38	3,780	line 10, c 3	47
48					48
49	TOTAL (lines 35 - 48)	880	$ 61,835		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	631	20,213	line 10, c 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	631	$ 20,213		53

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles K. Keigley	former Administrator	0	$ 19,041
Karlene Dotson	current Administrator	0	26,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,291

B. Administrative - Other

Description	Amount
Interest Expense	$ 19,995
TOTAL (agree to Schedule V, line 17, col. 3)	$ 19,995
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris, LLP	Legal Services	$ 85,295
Gallop Johnson & Newman	Legal Services	3,760
Anthony Eierman	Legal Services	3,500
Evans Law Firm	Legal Services	3,315
The Lowenbaum Partnership	Legal Services	165
Sorlin, Nuthrup, Hanna, Cullen & Co	Legal Services	3,908
LarsonAllen LLP	Audit Services	11,527
SIDC	Payroll Services	5,195
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 116,663

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,742
Unemployment Compensation Insurance	29,164
FICA Taxes	228,440
Employee Health Insurance	243,187
Employee Meals	90,728
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,336
Employee Gift/Relations	2,436
Employer Matching 403B Contribution	1,234
Employee Life & Disability Insurance	9,333
TOTAL (agree to Schedule V, line 22, col.8)	$ 659,600

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	844
Health Care Worker Background Check	1,060
(Indicate # of checks performed 53)	0
Patient Background Checks 4	64
Illinois Healthcare Association Dues	4,478
Dietary Manager's Association	155
Licensing Fees and Annual Report	631
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,232

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,011
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,011

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 - $ 4,478**

(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. $ **30,482** 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. $ **257,768**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **n/a**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **88,201** 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: **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.

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 constriction 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 Attachement 2
Schedule V Line 23 & 24

Line 23 - Inservice Training & Education

American Red Cross Rentals	2,078
Food Sanitation Course Instructor Fee	1,000
Study Materials	378
Total Line 23	**3,456**

Line 24 - Travel & Seminar

	Date	Registration Fee	Hotel	Gasoline	Meals	Total
Program Development Associates	Jan. 7, 2010	110				110
IHCA Convention & Trade Show	Sept. 13,14 &15	795	1,596	42	467	2,900
Total Line 24						**3,010**

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

Schedule V Reclassifications		Description
Nursing Supplies	(43)	Patient Background checks
Activity Other	2,400	Gym Rental Fee
Administrative Other	(19,694)	Interest expense
Dues/Subscriptions	1,119	+1,055 Employee Backgroup Checks/+64 Patient Background checks
Clerical/General Office	109	Office Supplies
Employee Benefits	(1,076)	-1,055 Employee Background Checks/-21 Patient Background checks
Interest	19,694	Interest expense
Other	(2,509)	-2,400 Gym Rental Fee / -109 Office Supplies
Net Adjustments	-	

Parents and Friends of the Specialized Living Center
Cost Report Attachment 4
IDPHID# 0026773
01/01/10 - 12/31/10

Board Members:

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

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

Parents and Friends of the Specialized Living Center
Cost Report Attachment 5
Page 19 Supplementary Schedule

Line 25 - Interest and other investment income

63,563.03	Prompt Pay Interest from the State of Illinois - Unrestricted
5,832.97	Bank interest - Unrestricted
69,396.00	Total