

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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 SLC

**Address:** 1450 Caseyville Avenue Swansea 62226  
 Number City Zip Code

**County:** St. Clair

**Telephone Number:** 6182777730 **Fax #** 6172775423

**HFS ID Number:** 37-1089886005

**Date of Initial License for Current Owners:** 1/1/1982

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501C-3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Shirley Saia **Telephone Number:** 618-277-7730, ext 3309

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 010107 to 123107 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.

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

**Officer or Administrator of Provider** (Type or Print Name) Charles K. Keigely

(Title) Administrator

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

**Paid Preparer** (Print Name and Title) \_\_\_\_\_

(Firm Name & Address) \_\_\_\_\_

(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Parents & Friends of the SLC

# 0026773 Report Period Beginning: 010107 Ending: 123107

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 n/a

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>34,250</u>	<u>340</u>		<u>34,590</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>34,250</u>	<u>340</u>		<u>34,590</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.77%

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

230 (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)

na/

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 010107 Ending: 123107

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	220,601	22,772	8,172	251,545		251,545	251,545			1
2	Food Purchase		167,766		167,766		167,766	167,766			2
3	Housekeeping	157,933	29,638	8,604	196,175		196,175	196,175			3
4	Laundry		6,118	12,952	19,070		19,070	19,070			4
5	Heat and Other Utilities			146,668	146,668		146,668	146,668			5
6	Maintenance	73,774	15,266	640	89,680		89,680	89,680			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>452,308</b>	<b>241,560</b>	<b>177,036</b>	<b>870,904</b>		<b>870,904</b>	<b>870,904</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,800	16,800		16,800	16,800			9
10	Nursing and Medical Records	1,989,521	72,480	48,359	2,110,360		2,110,360	2,110,360			10
10a	Therapy	20,980			20,980		20,980	20,980			10a
11	Activities	48,843	7,577	1,863	58,283		58,283	(1,863)	56,420		11
12	Social Services	26,195		1,530	27,725		27,725		27,725		12
13	CNA Training	120,348			120,348		120,348		120,348		13
14	Program Transportation		23,805		23,805		23,805		23,805		14
15	Other (specify):* seamstress/sewing exp	10,037	1,551		11,588		11,588		11,588		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,215,924</b>	<b>105,413</b>	<b>68,552</b>	<b>2,389,889</b>		<b>2,389,889</b>	<b>(1,863)</b>	<b>2,388,026</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	63,540		84	63,624		63,624	(84)	63,540		17
18	Directors Fees										18
19	Professional Services			82,613	82,613		82,613		82,613		19
20	Dues, Fees, Subscriptions & Promotions			14,606	14,606		14,606	(2,193)	12,413		20
21	Clerical & General Office Expenses	135,959	26,536	17,912	180,407		180,407		180,407		21
22	Employee Benefits & Payroll Taxes			535,163	535,163		535,163		535,163		22
23	Inservice Training & Education			4,092	4,092		4,092		4,092		23
24	Travel and Seminar			5,279	5,279		5,279		5,279		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			66,210	66,210		66,210		66,210		26
27	Other (specify):*			6,757	6,757		6,757	(6,533)	224		27
28	<b>TOTAL General Administration</b>	<b>199,499</b>	<b>26,536</b>	<b>732,716</b>	<b>958,751</b>		<b>958,751</b>	<b>(8,810)</b>	<b>949,941</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,867,731</b>	<b>373,509</b>	<b>978,304</b>	<b>4,219,544</b>		<b>4,219,544</b>	<b>(10,673)</b>	<b>4,208,871</b>		<b>29</b>

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

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

Facility Name & ID Number Parents & Friends of the SLC #0026773 Report Period Beginning: 010107 Ending: 123107

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			172,563	172,563		172,563	172,563			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,620	1,620		1,620	1,620			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			174,183	174,183		174,183	174,183			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			260,262	260,262		260,262	260,262			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			260,262	260,262		260,262	260,262			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,867,731	373,509	1,412,749	4,653,989		4,653,989	(10,673)	4,643,316		45

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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,863)	C11		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	(2,193)	C20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				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	(6,617)	C27/17		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (10,673)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (10,673)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

Parents & Friends of the SLC

ID# 0026773

Report Period Beginning: 010107

Ending: 123107

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49





Facility Name & ID Number Parents & Friends of the SLC

# 0026773

Report Period Beginning:

010107

Ending:

123107

**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			
		H.O.M.E. #1	Swansea	SLC Enrichment Center	Swansea	To provide recreational opportunities to developmentally disabled adults

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

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

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

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

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 010107 Ending: 123107

## 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	Agnes Schloemann	Board Member	Consultant	0.00	\$11,500 paid from Parents and Friends of the Specialized			\$		1
2					Living Center-Enrichment Center					2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Parents & Friends of the SLC

# 0026773

Report Period Beginning: 010107

Ending: 123107

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Community First Bank	X		Vehicle Loan	\$586.79	12/28/06	\$ 24,325	\$ 18,903	12/28/10	7.7500	\$ 1,620	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$586.79		\$ 24,325	\$ 18,903			\$ 1,620	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 24,325	\$ 18,903			\$ 1,620	15								

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , 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).			\$	#VALUE!	3
4. Real Estate Tax accrual used for 2007 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	#VALUE!	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	_____	8			
2003	_____	9			
2004	_____	10			
2005	_____	11			
2006	_____	12			
			<b>FOR BHF USE ONLY</b>		
			13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Parents & Friends of the SLC COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0026773

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>_____</u>	\$ <u>_____</u>

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick and frame Frame Protected non Combustible Number of Stories single

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

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

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

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

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

SLC Enrichment Center-to provide recreational opportunities to developmentally disabled adults. This is a gymnasium with no beds. Square footage is 7,528.

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	<u>Patient Care</u>		<u>1979</u>	<u>\$ 999</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 999</b>	3

Facility Name &amp; ID Number Parents &amp; Friends of the SLC

# 0026773

Report Period Beginning:

010107

Ending:

123107

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100		1982	1982	\$ 3,000,000	\$ 100,000	30	\$ 100,000		\$ 1,489,315	4
5			1984	1984	303,400	10,113	30	10,113		233,454	5
6			1984	1984	33,537		15			33,537	6
7											7
8											8
	<b>Improvement Type**</b>										
9		Building Improvements		1978	17,185		15			17,185	9
10		Various Improvements		1979	18,581		20			18,581	10
11		Metal Heater Pads-all pods		1981	5,815		15			5,815	11
12		Sport Court		1982	7,239		10			7,239	12
13		Playground Equipment		1982	10,364		10			10,364	13
14		Storage building		1982	8,927		15			8,927	14
15		Water Heater-Pod 3		1984	2,065		15			2,065	15
16		Draperies-all Pods and Core Building		1984	22,352		10			22,352	16
17		Drainage System		1984	23,286		10			23,286	17
18		Concrete Sport Court		1984	6,564		10			6,564	18
19		Sidewalk-Core Building to Pods 2 and 3		1984	1,050		10			1,050	19
20		Sidewalk-ERC to Maintenance Building		1985	1,632		10			1,632	20
21		Various Trees		1985	5,600		10			5,600	21
22		ERC Walk and Curb		1985	3,020		10			3,020	22
23		Pine Pavilion		1985	11,542		15			11,542	23
24		Security System		1985	868		15			868	24
25		Gym Dividers		1985	1,600		5			1,600	25
26		Storage Shelves		1985	1,010		5			1,010	26
27		Central Vacuum System		1985	7,680		10			7,680	27
28		Asphalt Running Track		1985	8,185		10			8,185	28
29		Faucets		1985	2,160		20			2,160	29
30		Power Mixing Valve-Core Building		1985	561		10			561	30
31		ERC Parking Lot		1984	2,176		10			2,176	31
32		Reading Lights-all pods		1985	1,689		10			1,689	32
33		Sidewalk-Core Building to ERC		1984	1,900		10			1,900	33
34		Light Fixtures-all pods		1985	145		10			145	34
35		Power Panel/Fire Alarm		1985	1,285		20			1,285	35
36		Bathroom Fixtures-all pods		1985	2,050		10			2,050	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Parents &amp; Friends of the SLC

# 0026773

Report Period Beginning:

010107

Ending:

123107

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire Alarm System	1986	\$ 4,901	\$	20	\$	\$	\$ 4,901	37
38	Window replacement-Pods	1986	244		10			244	38
39	Landscaping	1986	892		10			892	39
40	Power Mixer Valve-Core Building	1986	214		10			214	40
41	Bathroom vanities-all pods	1986	465		10			465	41
42	Overhead Basketball Goal	1986	3,422		10			3,422	42
43	Craperies-Core Building (Business Office)	1986	254		10			254	43
44	Remodel Visitors Room-Core Building	1986	646		10			646	44
45	Light Fixtures-all pods	1988	1,162		10			1,162	45
46	Heat Booster-Pod5	1988	712		10			712	46
47	Door Pump/Motor-Core Building Electric Door	1988	858		10			858	47
48	Marble Counter Tops-all pods	1989	1,818		10			1,818	48
49	Chrome Lav.-all pods	1989	1,800		10			1,800	49
50	Back Flow Preventor-Core Building (waterlines)	1989	1,293		10			1,293	50
51	Booster Heater-Pod 7	1999	779		10			779	51
52	Water Heater-Pods6 (booster)	1990	760		10			790	52
53	Repair A/C (Core building)	1990	2,198		5			2,198	53
54	Repair A/C-Pod 5	1990	1,239		5			1,239	54
55	New A/C unit-Pod 3	1990	3,525		10			3,525	55
56	Water Heater-Pod2	1990	1,522		10			1,522	56
57	Water Heater-Pod 4 (Booster)	1990	760		10			760	57
58	Solid Core doors-Pod 5	1990	619		10			619	58
59	Water Heater-Pod 6 (booster)	1991	820		10			820	59
60	Water Heater-Pod 7	1991	1,592		10			1,592	60
61	Water Heater-Pod 3 (booster)	1991	810		10			810	61
62	Circuit Breaker Box-Core Building	1991	679		10			679	62
63	A/C Unit-Compressor-Pod 2	1991	975		10			975	63
64	A/C Unit-Compressor-Pod 5	1991	1,285		10			1,285	64
65	Fire Safety/Smoke Detectors-All Pods	1992	864		10			864	65
66	A/C Unit-Pod 2 (Unit 2)	1992	3,642		10			3,642	66
67	A/C Unit-Pod 4(Unit 1)	1992	3,642		10			3,642	67
68	Vanities-Bathroom-all Pods	1992	3,305		10			3,305	68
69	Electric Heaters-Pod 2 (boosters)	1992	810		10			810	69
70	TOTAL (lines 4 thru 69)		\$ 3,561,975	\$ 110,113		\$ 110,113	\$	\$ 1,981,374	70

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

Facility Name &amp; ID Number Parents &amp; Friends of the SLC

# 0026773

Report Period Beginning:

010107

Ending:

123107

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,561,975	\$ 110,113		\$ 110,113	\$	\$ 1,981,374	1
2	Water Heaters-Pods 2 and 4	1993	5,491		10			5,491	2
3	A/C Unit-Pod 2 (Unit 1)	1993	3,642		10			3,642	3
4	Window replacements (Pods)	1994	400		10			400	4
5	Painted All Pods-labor/materials	1994	10,644		5			10,644	5
6	Additional Smoke Detectors	1994	575		10			575	6
7	Various Corrections to Code	1994	1,097		10			1,097	7
8	Water Heater-Pod 5 (booster)	1994	860		10			860	8
9	Water Heater-Pod 6	1995	1,950		10			1,950	9
10	A/C Unit-Pod 6 (Unit 2)	1995	3,953		10			3,953	10
11	A/C Unit-ERC	1996	1,774		10			1,774	11
12	Carpeting-all pods	1996	38,806		7			38,806	12
13	Painted Pods-touch up (Labor and Materials)	1996	3,356		5			3,356	13
14	Water Heater-Pod 5 (booster)	1996	2,032		10			2,032	14
15	Booster Heater-Pod 5	1996	951		10			951	15
16	Booster Heater-Spare	1997	952		10			952	16
17	Carpeting-Core Building	1997	6,041		7			6,041	17
18	Water Heater-Booster (Dietary)	1997	1,585		7			1,585	18
19	Walk in Freezer Repairs	1998	1,590		7			1,590	19
20	Water Heater-120 Gallon	1998	2,152		7			2,152	20
21	Water Heater-120 Gallon	2000	2,256		7			2,256	21
22	Gymnasium Roof	2000	21,635	1,442	15	1,442		10,217	22
23	Renovation of Pod 2	2001	66,904	9,558	7	9,558		66,904	23
24	Renovation of Pod4	2001	7,746	1,107	7	1,107		6,916	24
25	Fire Supression System-Dietary	2002	2,740	391	7	391		1,989	25
26	Water Softener System	2004	1,960	280	7	280		1,120	26
27	Condensing Unit(3 1/2 ton)	2004	742	106	7	106		371	27
28	A/C Unit-Pod 2 (Unit 1)	2004	4,261	609	7	609		2,080	28
29	A/C Compressor Unit-Core Building	2004	14,839	2,120	7	2,120		7,243	29
30	Cabinets in Pod 3	2006	812	81	10	81		156	30
31	Flooring in Pods and Nurses' Office	2006	55,833	3,722	15	3,722		5,893	31
32	Carpet Squares in Pods	2006	2,298	460	5	460		728	32
33	Parking Lot gravel-ERC	1985	1,247		10			1,247	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,833,099	\$ 129,989		\$ 129,989	\$	\$ 2,176,345	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,833,099	\$ 129,989		\$ 129,989		\$ 2,176,345		1
2									2
3	Door/ERC Building	1985 564	19	30	19		419		3
4	Fire alarm panel in core building	2007 5,431	272	20	272		272		4
5	Painting of all Pods	2007 49,800	1,660	5	1,660		1,660		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	TOTAL (lines 1 thru 33)	\$ 3,888,894	\$ 131,940		\$ 131,940		\$ 2,178,696		34

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

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	\$ 160,696	\$ 21,096	\$ 21,096	\$		\$ 89,596	71
72	Current Year Purchases	33,640	3,885	3,885		5	3,885	72
73	Fully Depreciated Assets	377,688	800	800		5	377,688	73
74								74
75	TOTALS	\$ 572,024	\$ 25,781	\$ 25,781	\$		\$ 471,169	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	1999 Dodge Mini Van	1999	\$ 15,004	\$	\$	\$	5	\$ 15,004	76
77	Patient Care	2000 used riding mower	2001	750				5	750	77
78	Patient Care	1991 Chevy Astro Van-w/c lift	2002	10,130	169	169		5	10,130	78
79	Patient Care	1991 Chevy Van-w/c lift	2002	7,000	1,167	1,167		5	7,000	79
80	TOTALS			\$ 32,884	\$ 1,336	\$ 1,336	\$		\$ 32,884	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)	\$ 4,629,502	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 172,563	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 172,563	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,775,592	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2008                      \$ \_\_\_\_\_
13. \_\_\_\_\_ /2009                      \$ \_\_\_\_\_
14. \_\_\_\_\_ /2010                      \$ \_\_\_\_\_

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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	1,385	14,544		15,929
4	Clinical Wages (b)		79,780		79,780
5	In-House Trainer Wages (c)	2,218	22,421		24,639
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 3,603	\$ 116,745	\$	\$ 120,348
10	SUM OF line 9, col. 1 and 2 (e)	\$ 120,348			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ n/a

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	42
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>46</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10/3	visits		111	5,492		111	5,492	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	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	111	\$ 5,492	\$	111	\$ 5,492	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Parents & Friends of the SLC# 0026773Report Period Beginning: 010107

Ending:

123107**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 123107

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 591,182	\$ 591,182	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,350,487	1,350,487	3
4	Supply Inventory (priced at <u>cost</u> )	8,460	8,460	4
5	Short-Term Investments			5
6	Prepaid Insurance	3,920	11,324	6
7	Other Prepaid Expenses	7,279	7,279	7
8	Accounts Receivable (owners or related parties)	54,998	54,998	8
9	Other(specify): <u>NAT reimbursement</u>	15,744	15,744	9
	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,032,070	\$ 2,039,474	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,456,085	3,456,085	14
15	Leasehold Improvements, at Historical Cost	499,757	499,757	15
16	Equipment, at Historical Cost	739,598	739,598	16
17	Accumulated Depreciation (book methods)	(2,778,635)	(2,778,635)	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
	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,916,805	\$ 1,916,805	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,948,875	\$ 3,956,279	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 203,239	\$ 203,239	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	18,903	18,903	29
30	Accrued Salaries Payable	265,271	265,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,559	1,559	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued expenses</u>	6,820	6,820	36
37				37
	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 495,792	\$ 495,792	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,352	2,352	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,352	\$ 2,352	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 498,144	\$ 498,144	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,450,731	\$ 3,458,135	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,948,875	\$ 3,956,279	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,344,281	1
2	Restatements (describe):		2
3	<u>prior period adjustment -see audit report</u>	44,068	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,388,349	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	62,382	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)	\$ 62,382	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 3,450,731	24 *

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

Facility Name & ID Number Parents & Friends of the SLC

# 0026773

Report Period Beginning: 010107

Ending: 123107

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,610,573	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,610,573	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	55,977	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 55,977	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	45,545	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 45,545	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	3,000	27
28	<b>garnishment service charges</b>	1,206	28
28a	<b>miscellaneous income</b>	70	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,276	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,716,371	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	870,904	31
32	Health Care	2,389,889	32
33	General Administration	958,751	33
<b>B. Capital Expense</b>			
34	Ownership	174,183	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	260,262	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,653,989	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	62,382	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 62,382	43

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

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

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

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

Facility Name & ID Number Parents & Friends of the SLC

# 0026773

Report Period Beginning:

010107

Ending:

123107

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,345	1,458	\$ 38,650	\$ 26.51	1
2	Assistant Director of Nursing	740	814	16,557	20.34	2
3	Registered Nurses					3
4	Licensed Practical Nurses	17,697	18,834	331,994	17.63	4
5	CNAs & Orderlies					5
6	CNA Trainees	11,811	11,811	95,709	8.10	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,909	2,105	20,981	9.97	8
9	Activity Director	1,922	2,087	28,522	13.67	9
10	Activity Assistants	1,961	2,468	20,320	8.23	10
11	Social Service Workers	1,891	2,111	26,195	12.41	11
12	Dietician					12
13	Food Service Supervisor	3,763	4,261	58,891	13.82	13
14	Head Cook	6,822	7,227	59,227	8.20	14
15	Cook Helpers/Assistants	1,052	1,100	8,575	7.80	15
16	Dishwashers	11,967	12,463	93,908	7.53	16
17	Maintenance Workers	5,859	6,515	73,774	11.32	17
18	Housekeepers	15,151	15,661	157,933	10.08	18
19	Laundry					19
20	Administrator	1,960	2,274	63,540	27.94	20
21	Assistant Administrator					21
22	Other Administrative	3,723	4,240	68,218	16.09	22
23	Office Manager	1,631	1,900	36,345	19.13	23
24	Clerical	1,842	2,059	22,922	11.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,793	11,667	141,843	12.16	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	169,033	182,016	1,460,477	8.02	30
31	Medical Records	798	876	8,474	9.67	31
32	Other Health Care training coordinators	1,080	2,160	24,639	11.41	32
33	Other(specify) <u>seamstress</u>	1,129	1,233	10,037	8.14	33
34	TOTAL (lines 1 - 33)	275,879	297,340	\$ 2,867,731 *	\$ 9.64	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	164	\$ 8,172	1/3	35
36	Medical Director	96	16,800	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant	19	418	10/3	38
39	Pharmacist Consultant	72	2,160	10/3	39
40	Physical Therapy Consultant	41	1,990	10/3	40
41	Occupational Therapy Consultant	133	6,775	10/3	41
42	Respiratory Therapy Consultant			10/3	42
43	Speech Therapy Consultant	106	6,450	10/3	43
44	Activity Consultant				44
45	Social Service Consultant	25	1,530	12/3	45
46	Other(specify) <u>Psychologist</u>	300	19,788	10/3	46
47	<u>Psychiatrist</u>	48	4,200	10/3	47
48					48
49	TOTAL (lines 35 - 48)	1,004	\$ 68,283		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	33	1,085	9/3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	33	\$ 1,085		53

Facility Name & ID Number Parents & Friends of the SLC

# 0026773

Report Period Beginning: 010107

Ending: 123107

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Chad M. Rollins	administrator	0	\$ 50,770	Workers' Compensation Insurance	\$ 39,612	IDPH License Fee	\$		
Charles K. Keigley	administrator	0	12,770	Unemployment Compensation Insurance	11,182	Advertising: Employee Recruitment	6,603		
				FICA Taxes	215,855	Health Care Worker Background Check			
				Employee Health Insurance	193,620	(Indicate # of checks performed <u>57</u> )	1,146		
				Employee Meals	63,326	Patient Background Checks <u>6</u>	96		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Assoc dues	5,520		
				Employee physicals	4,831	(less 29.31% lobbying costs)	(1,618)		
				Employee relations/gifts	6,737	Professional dues and subscriptions	426		
						Licensing fees and annual reports	240		
						Non Allowable adertising expenses	575		
						Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,540	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 535,163		\$ 12,988			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description			Description		
Bank Charges			\$ 84	Line #			Amount		
							Out-of-State Travel		
							\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 84	TOTAL			In-State Travel		
C. Professional Services							Seminar Expense		
Vendor/Payee	Type	Amount							
Gallop, Johnson and Neuman	legal services	\$ 10,887					5,279		
DLA Piper, US LLP	legal services	32,293							
Duane Morris, LLP	legal services	21,859					Entertainment Expense		
Michigan Peer Review	peer review	1,705					( )		
Rice, Sullivan and Co., Ltd.	audit services	10,210					(agree to Sch. V, line 24, col. 8)		
SIDC	payroll services	5,659					\$ 5,279		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 82,613	TOTAL					

\* Attach copy of IMRF notifications

\*\*See instructions.





Schedule XI, Ownership Costs, Section D, Vehicle Depreciation									
Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation	
Prior year adj.								169	
Patient Care	1979 Ford Truck	1982	4500				5	4500	
Patient Care	Snow Plow	1982	1465				5	1465	
Patient Care	1988 Tractor	1988	8356				5	8356	
Patient Care	1990 Van w/ w/c lift	1991	19034				4	19034	
Patient Care	wheelchair lift	1991	2885				4	2885	
Patient Care	1993 Plymouth Van	1993	14547				4	14547	
Patient Care	1997 Riding Mower	1997	1000				5	1000	
Patient Care	2002 Riding Mower	2002	1033	69	69		4	1033	
Patient Care	2003 Riding Mower	2003	2577	214	214		4	2577	
Patient Care	1993 Ford Van	2003	16983				5	16983	
Patient Care	1991 E150 Ford Van	2004	2150	717	717		3	2150	
Patient Care	1994 Dodge Caravan	2004	2150	717	717		3	2150	
Patient Care	Repairs for Chevy Astro	2005	779	259	259		3	605	
Patient Care	1987 Dodge Pick Up	2005	5715	1905	1905		3	3810	
Patient Care	2001 Dodge Ram Van	2006	8645	1297	1297		5	2593	
Patient Care	2007 Dodge Caravan Van	2006	39405	7881	7881		5	8538	
Patient Care	1991 Astro Van improvements	2007	623	114	114		5	114	
Patient Care	1991 Chevrolet van improvements	2007	966	145	145		5	145	
Patient Care	1991 van-improvements	2007	1888	189	189		3	189	
			134701	13507	13507			92843	

Cost Center Adjustments to Expenses, Schedule V, lines 11, 17, 20 and 27  
Adjustment Detail, line 29

year end disposal of state purchased items	5,579
bank service charges	84
non allowable lobbying costs assoc. with IHCA membership dues	1,618
non allowable membership fees	575
DISH TV	1,863
non allowable expenses	954
	<hr/>
	10,673
allowable expense of daily newspaper delivery for resident use	224

Board of Directors:

Orville Lester  
Adelaide Sauthoff  
Edward Nida  
John Simpson  
Arland Lester, Sr.  
Nila Smith  
Agnes Schloemann  
Wilma Postin

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

Schedule XX, General Information, Legal Fees

Summary of Legal Services:

Period ending 1/31/07-general corporate matters	851.90
Period ending 2/28/07-general corporate matters	307.60
Period ending 3/31/07-general corporate matters	156.23
Period ending 4/30/07-general corporate matters	2,391.00
Period ending 4/30/07-general corporate matters	115.00
Period ending 4/30/07-general corporate matters	8,419.84
Period ending 5/31/07-general corporate matters	2,192.08
Period ending 5/31/07-general corporate matters	7,959.32
Period ending 5/31/07-general corporate matters	6,657.20
Period ending 6/30/07-general corporate matters	1,416.00
Period ending 6/30/07-general corporate matters	1,209.00
Period ending 6/30/07-general corporate matters	5,599.00
Period ending 7/31/07-general corporate matters	2,210.40
Period ending 7/31/07-general corporate matters	1,152.80
Period ending 8/31/07-general corporate matters	3,397.50
Period ending 8/31/07-general corporate matters	649.10
Period ending 9/30/07-general corporate matters	1,990.50
Period ending 9/30/07-general corporate matters	1,279.52
Period ending 9/30/07-general corporate matters	414.00
Period ending 10/31/07-general corporate matters	897.00
Period ending 10/31/07-general corporate matters	2,254.50
Period ending 10/31/07-general corporate matters	6,692.40
Period ending 11/30/07-general corporate matters	1,632.08
Period ending 11/30/07-general corporate matters	1,265.50
Period ending 11/30/07-general corporate matters	2,096.60
Period ending 12/31/07-general corporate matters	46.00
Period ending 12/31/07-general corporate matters	238.50
Period ending 12/31/07-general corporate matters	1,548.80
	<u>65,039.37</u>

Cost Center Expenses - Schedule V, Line 24 - Travel and Seminar

Title: Sanitation Refresher Course  
Sponsored by: Linda Schindler  
Attended by: Dana Kobb, Food Service Manager  
Dawn Palmer, Asst. Food Service Manager  
Mable Haynes, Cook  
Thomas Michal, Cook  
Cassy Escobedo, Asst. Cook  
Date: 3/30/07  
Location: Belleville, IL  
Justification: To meet food sanitation regulations  
Cost: \$90.00

Title: Refrigeration Service  
Sponsored by: Refrigeration Service Engineers Society  
Attended by: Dave Losser, Physical Plant Director  
Date: 4/10/07  
Location: South Elgin, IL  
Justification: To attend educational sessions on refrigeration  
Cost: \$ 173.00

Title: Discipline and Termination/Recruiting and Hiring  
Sponsored by: Southwestern Illinois College  
Attended by: James Patterson, QMRP  
Joe Lust, QMRP  
Kathy Algibers, QMRP  
Tanya Mathis, QMRP  
Kelly Staebel, QMRP  
Melissa Kenney, QMRP

Date: 2/15/07  
Location: Belleville, IL  
Justification: To attend educational seminars to improve supervisory skills  
Cost: \$588.00

Title: Association of Public Developmental Disabilities Administrators Conference  
Sponsored by: APDDA  
Attended by: Chad Rollins, Administrator  
Date: 2/18-22/07  
Location: Chandler, AZ  
Justification: to attend education session on Federal and state legislation  
and to receive updates on trends and changes in the services  
To persons with developmental disabilities.  
Cost: \$919.58

Title: 36 Hour Activity Director's Course  
Sponsored by: Outcome Services of Illinois  
Attended by: Krystal Gruenenfelder, Activity Director  
Dates: 2/27-2/28/07, 3/6-3/7/07 and 3/13-3/14/07  
Location: Breesse, IL  
Justification: To meet Public Health regulations for Activity Director  
Cost: \$400.00

Title: Clinical Updates in Mental Health and Developmental Disabilities  
Sponsored by: SIU School of Medicine  
Attended by: Chad Rollins, Administrator  
Location: Springfield, IL  
Cost: \$100.00  
Justification: Educational clinical sessions for staff that provide care for mental health services to persons with developmental disabilities

Cost Center Expenses - Schedule V, Line 24 - Travel and Seminar (continued)

Title: Fundamentals of Direct Digital Controls  
Sponsored by: Refrigeration Service Engineers Society  
Attended by: Dave Losser, Physical Plant Director  
Date: 10/13/07  
Location: South Elgin, IL  
Justification: To attend educational sessions on refrigeration  
Cost: \$ 150.00

Title: Director of Nurses' Fall Conference  
Sponsored by: Director of Nurses' Association of St. Clair County  
Attended by: Pam Woodward, Director of Nursing  
Date: 9/18/07  
Location: Fairview Heights, IL  
Justification: To attend educational sessions on nursing services  
Cost: \$73.00

Title: Nursing Home Administrator's Association Annual Trade Show  
Sponsored by: NHAA  
Attended by: Charles Kegley, Administrator  
Dates: 11/6-11/7/07  
Location: Springfield, IL  
Justification: To attend educational sessions relating to the care of developmentally disabled adults  
Cost: \$125.00

Title: What is Immediate Jeopardy and What is Not?  
Sponsored by: Illinois Health Care Association  
Attended by: Charles Kegley, Administrator  
Date: 10/24/07  
Location: Mt. Vernon, IL  
Justification: To provide clarification as to what circumstances are and are not Immediate Jeopardy violations; when they should be cited and when they should not.  
Cost: \$85.00

Title: Illinois Health Care Association Annual Convention and Trade Show  
Sponsored by: Illinois Health Care Association  
Attended by:  
Chad Rollins, Administrator  
Candi Morrison, QMRP  
Diane Van, Administrator on Duty  
Dana Kobb, Food Service Manager  
Linda Schuhard, Quality Assurance  
Joe Lust, QMRP  
Kathy Algibers, AMRP  
Kelly Staebel, QMRP  
Kim McCarty, Personnel Director  
Krystal Gruenenfelder, Activity Director  
Marion Blaylock, Social Service Designee  
Dates: 8/17-8/20/07  
Location: Peoria, IL  
Justification: To attend educational sessions relating to the care of the developmentally disabled adult  
Cost: \$2,226.71

Cost Center Expenses - Schedule V, Line 24 - Travel and Seminar (continued)

Title: AED Training  
Sponsored by: American Red Cross  
Attended by:  
Nancy Farrar, Assistant Director of Nursing  
Mandi Martin, LPN  
Rita Brumburg, LPN  
Date: 7/18/07  
Justification: Receive defibrillator training  
Cost: \$128.50