



Facility Name & ID Number Parents & Friends of the Specialized Living Center# 0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>100</u>	Intermediate/DD	<u>100</u>	<u>36,600</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>100</u>	<u>36,600</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>34,523</u>	<u>60</u>		<u>34,583</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>34,523</u>	<u>60</u>		<u>34,583</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.49%

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

367 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

n/aF. Does the facility maintain a daily midnight census? yes

G. Do pages 3 &amp; 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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Parents & Friends of the Specialized Living C # 0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	220,989	24,704	8,818	254,511		254,511	254,511			1
2	Food Purchase		175,822		175,822		175,822	175,822			2
3	Housekeeping	84,705	21,738	9,011	115,454		115,454	115,454			3
4	Laundry		4,132	13,925	18,057		18,057	18,057			4
5	Heat and Other Utilities			150,101	150,101		150,101	150,101			5
6	Maintenance	73,277	15,105	9,756	98,138		98,138	98,138			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>378,971</b>	<b>241,501</b>	<b>191,611</b>	<b>812,083</b>		<b>812,083</b>	<b>812,083</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,400	14,400		14,400	14,400			9
10	Nursing and Medical Records	2,251,957	73,946	44,313	2,370,216		2,370,216	2,370,216			10
10a	Therapy	20,957			20,957		20,957	20,957			10a
11	Activities	47,914	12,004		59,918		59,918	(3,268)	56,650		11
12	Social Services	30,262		1,485	31,747		31,747		31,747		12
13	CNA Training	96,808			96,808		96,808		96,808		13
14	Program Transportation		18,186	7,505	25,691		25,691		25,691		14
15	Other (specify):* seamstress/sewing exp	10,640	1,436		12,076		12,076		12,076		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,458,538</b>	<b>105,572</b>	<b>67,703</b>	<b>2,631,813</b>		<b>2,631,813</b>	<b>(3,268)</b>	<b>2,628,545</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	64,091		84	64,175		64,175	(84)	64,091		17
18	Directors Fees										18
19	Professional Services			50,213	50,213		50,213		50,213		19
20	Dues, Fees, Subscriptions & Promotions			8,445	8,445		8,445	(2,212)	6,233		20
21	Clerical & General Office Expenses	139,368	22,663	21,126	183,157		183,157		183,157		21
22	Employee Benefits & Payroll Taxes			592,366	592,366		592,366		592,366		22
23	Inservice Training & Education			1,064	1,064		1,064		1,064		23
24	Travel and Seminar			2,255	2,255		2,255		2,255		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,378	47,378		47,378		47,378		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>203,459</b>	<b>22,663</b>	<b>722,931</b>	<b>949,053</b>		<b>949,053</b>	<b>(2,296)</b>	<b>946,757</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,040,968</b>	<b>369,736</b>	<b>982,245</b>	<b>4,392,949</b>		<b>4,392,949</b>	<b>(5,564)</b>	<b>4,387,385</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 Specialized Living Center #0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			177,892	177,892		177,892	177,892			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			372	372		372	372			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>			178,264	178,264		178,264	178,264			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			249,860	249,860		249,860	249,860			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			249,860	249,860		249,860	249,860			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,040,968	369,736	1,410,369	4,821,073		4,821,073	(5,564)	4,815,509		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	(3,268)	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	(2,212)	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 Bank Charges	(84)	C17		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (5,564)		\$	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>	\$ (5,564)		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.

		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						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 Specialized Living Center

ID# 0026773

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line Reference

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	<b>Total</b>	0	49





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

# 0026773

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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 Community		SLC Enrichment	Swansea	To provide
		Integration Services	Belleville			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 Specialized Living # 0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	\$3,425 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 Specialized Living Center # 0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

Facility Name & ID Number Parents & Friends of the Specialized Living C # 0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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	12/28/09	\$ 24,325	\$	12/28/10	0.0775	\$ 229	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Community First Bank		x	Line of Credit	none	3/15/2008	as needed		3/15/2009	0.0525	143	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$586.79		\$ 24,325	\$			\$ 372	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	\$			\$ 372	15								

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 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 2008 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:					
2003	_____	8			
2004	_____	9			
2005	_____	10			
2006	_____	11			
2007	_____	12			
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2007	\$			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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>		\$ _____	\$ _____

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 combust 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 Specialized Living Center

# 0026773

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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		\$ 1,589,315	4
5			1984	1984	303,400	10,113	30	10,113		243,567	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 Specialized Living Center

# 0026773

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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 Replacements-all pods	1986	244		10			244	38
39	Landscaping1986	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	Draperies-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-Pod 5	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-Pod7	1989	779		10			779	51
52	Water Heater-Pod 6 (booster)	1990	790		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-Pod 2	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 Saftery/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	Bathroom Vanities-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)		\$ 3,562,005	\$ 110,113		\$ 110,113	\$	\$ 2,091,487	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 Specialized Living Center

# 0026773

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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>		\$ 3,562,005	\$ 110,113		\$ 110,113	\$	\$ 2,091,487	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 fo Coade	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 Unite-ERC	1996	1,774		10			1,774	11
12	Carpeting-all pods	1996	38,806		7			38,806	12
13	Painted Pods-touched up (Labor and Material)	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	Gym Roof	2000	21,635	1,442	15	1,442		11,659	22
23	Renovation of Pod 2	2001	66,904		7			66,904	23
24	Renovation of Pod 4	2001	7,746	830	7	830		7,746	24
25	Fire Supression System-Dietary	2002	2,740	391	7	391		2,381	25
26	Water Softener System	2004	1,960	280	7	280		1,400	26
27	Condensing Unit (3 1/2 ton)	2004	742	106	7	106		477	27
28	A/C Unit-Pod 2 (Unit 1)	2004	4,261	609	7	609		2,689	28
29	A/C Compressor Unit-Core Building	2004	14,839	2,120	7	2,120		9,362	29
30	Cabinets in Pod 3	2006	812	81	10	81		237	30
31	Flooring in Pods and Nurses' Office	2006	55,833	3,722	15	3,722		9,616	31
32	Carpet Squares in Pods	2006	2,298	460	5	460		1,188	32
33	Parking Lot gravel-ERC	1985	1,247		10			1,247	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,833,129	\$ 120,154		\$ 120,154	\$	\$ 2,296,500	34

\*\*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:

01/01/08

Ending:

12/31/08

**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		\$ 3,833,129	\$ 120,154		\$ 120,154	\$	\$ 2,296,500	1
2	Door/Ec Building	1985	564	19	30	19		438	2
3	Fire Alarm Panel in Core Building	2007	5,431	272	20	272		543	3
4	Painting of all pods	2007	49,890	9,960	5	9,960		11,620	4
5	Blinds in all pods	2008	10,700	981	10	981		981	5
6	Water Heater/120 gallon and installation (stock)	2008	4,843	807	5	807		807	6
7	Door frames (6)	2008	3,296	247	10	247		247	7
8	Core Building Roof	2008	46,873	835	20	835		835	8
9	clean out in kitchen	2008	1,450	114	10	114		114	9
10	motor for a/c unit in core building	2008	914	53	10	53		53	10
11	replacement of fire alarm panel	2008	3,398	99	20	99		99	11
12	replacement of 7.5 ton a/c unit in House 6	2008	6,253	365	10	365		365	12
13	a/c replacement in House 3	2008	2,636	132	10	132		132	13
14	booster water heter-House 5	2008	2,953	49	5	49		49	14
15	replacement of squirrel cage for House 6	2008	4,370	146	10	146		146	15
16	roof repairs for pods 2, 4, 5 and 6	2008	24,968	832	5	832		832	16
17	starter assemblies in Houses 2, 4, 5 and 6	2008	3,802	32	10	32		32	17
18	replacement of condenser motor in core building a/c	2008	1,517	13	10	13		13	18
19	smoke detectors and installation (7)	2008	1,453	12	10	12		12	19
20	audit adjustment	2008	3,002	(3,002)		(3,002)			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)		\$ 4,011,442	\$ 132,120		\$ 132,120	\$	\$ 2,313,818	34

\*\*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: 01/01/08 Ending: 12/31/08

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	\$ 194,336	\$ 24,322	\$ 24,322	\$	5	\$ 117,803	71
72	Current Year Purchases	63,607	9,288	9,288		5	9,288	72
73	Fully Depreciated Assets	441,605				5	441,605	73
74	audit adjustment	376	(39)	(39)				74
75	TOTALS	\$ 699,924	\$ 33,571	\$ 33,571	\$		\$ 568,696	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				5	10,130	78
79	Patient Care	1991 Chevy Van-w/c lift	2002	7,000				5	7,000	79
80	TOTALS			\$ 32,884	\$	\$	\$		\$ 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)		\$ 4,878,953	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 177,892	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 177,892	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ #REF!	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,020,445	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>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)	2,162	15,135		17,297
4	Clinical Wages (b)		68,770		68,770
5	In-House Trainer Wages (c)	2,148	8,593		10,741
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 4,310	\$ 92,498	\$	\$ 96,808
10	SUM OF line 9, col. 1 and 2 (e)	\$ 96,808			

**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	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>31</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		122	6,150		122	6,150	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	<b>TOTAL</b>			\$	122	\$ 6,150	\$	122	\$ 6,150	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 Specialized Living Center # 0026773 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	\$ 1,752,102	\$ 1,752,102	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	544,456	544,456	3
4	Supply Inventory (priced at <u>cost</u> )	9,718	9,718	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,401	19,401	6
7	Other Prepaid Expenses	7,400	7,400	7
8	Accounts Receivable (owners or related parties)	26,492	26,492	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,359,569	\$ 2,359,569	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	4,011,832	4,011,832	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	867,121	867,121	16
17	Accumulated Depreciation (book methods)	(3,020,444)	(3,020,444)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,858,509	\$ 1,858,509	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,218,078	\$ 4,218,078	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 536,485	\$ 536,485	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	684	684	29
30	Accrued Salaries Payable	286,081	286,081	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,286	9,286	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				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 832,536	\$ 832,536	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 832,536	\$ 832,536	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,385,542	\$ 3,385,542	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,218,078	\$ 4,218,078	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,450,731	1
2	Restatements (describe):		2
3	<u>prior period adjustment-see audit report</u>	25,291	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,476,022	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(90,480)	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)	\$ (90,480)	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)	\$ 3,385,542	24 *

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

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 4,662,164	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,667,973	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	34,320	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>	\$ 34,320	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	300	24
25	Interest and Other Investment Income***	11,628	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,928	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	13,006	27
28	<b>garnishment service charges</b>	1,241	28
28a	<b>miscellaneous income</b>	2,125	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 16,372	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,730,593	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	812,083	31
32	Health Care	2,631,813	32
33	General Administration	949,053	33
<b>B. Capital Expense</b>			
34	Ownership	178,264	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	249,860	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,821,073	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(90,480)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (90,480)	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.

\*\*\*\*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:

01/01/08

Ending:

12/31/08

**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	1,777	2,080	\$ 59,744	\$ 28.72	1
2	Assistant Director of Nursing	1,930	2,133	41,432	19.42	2
3	Registered Nurses	40	40	716	17.90	3
4	Licensed Practical Nurses	18,299	20,233	348,947	17.25	4
5	CNAs & Orderlies					5
6	CNA Trainees	10,808	10,808	86,067	7.96	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,856	2,081	20,957	10.07	8
9	Activity Director	1,942	2,121	29,375	13.85	9
10	Activity Assistants	1,634	1,742	18,539	10.64	10
11	Social Service Workers	1,943	2,131	30,262	14.20	11
12	Dietician					12
13	Food Service Supervisor	3,492	4,277	57,633	13.48	13
14	Head Cook	4,021	4,555	44,827	9.84	14
15	Cook Helpers/Assistants	937	944	8,552	9.06	15
16	Dishwashers	12,069	12,721	109,978	8.65	16
17	Maintenance Workers	5,585	6,099	73,277	12.01	17
18	Housekeepers	6,716	7,471	84,705	11.34	18
19	Laundry					19
20	Administrator	1,883	2,080	64,091	30.81	20
21	Assistant Administrator					21
22	Other Administrative	3,658	4,240	70,089	16.53	22
23	Office Manager	1,488	1,900	34,145	17.97	23
24	Clerical	1,820	2,075	23,025	11.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,588	8,345	135,966	16.29	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	149,212	162,306	1,665,151	10.26	30
31	Medical Records	1,348	1,487	12,109	8.14	31
32	Other Health Care training coord.	683	786	10,741	13.67	32
33	Other(specify) <u>seamstress</u>	1,133	1,241	10,640	8.57	33
34	TOTAL (lines 1 - 33)	241,862	263,896	\$ 3,040,968 *	\$ 11.52	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	176	\$ 7,838	1/3	35
36	Medical Director	96	14,400	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	1,920	10/3	39
40	Physical Therapy Consultant	29	1,425	10/3	40
41	Occupational Therapy Consultant	116	5,800	10/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	94	5,660	10/3	43
44	Activity Consultant				44
45	Social Service Consultant	25	1,485	12/3	45
46	Other(specify) <u>Psychologist</u>	300	19,788	10/3	46
47	<u>Psychiatrist</u>	36	3,570	10/3	47
48					48
49	TOTAL (lines 35 - 48)	944	\$ 61,886		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53





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

# 0026773

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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 Assoc. \$5,244
- (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? n/a
- (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? n/a
- (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. \$ 27,955 Line 10/25
- (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. n/a
- (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. \$ 249,860  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 69,320 Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (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. \$ n/a  
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: GMCH The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. n/a
- (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.



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

bank service charges	84
non allowable lobbying costs associated with IHCA membership dues	1,882
non allowable membership fees	330
DISH/Direct TV	<u>3,268</u>
	5,564
allowable expense of daily newspaper delivery for resident use	199

Board Members:

Orville Lester

Edward Nida

Arland Lester

Donna Harris

Nila Smith

Wilma Postin

Agnes Schloeman (partial year)

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 1/31/08-general corporate matters	1,190
Period ending 2/29/08-general corporate matters	903
Period ending 3/31/08-general corporate matters	1,685
Period ending 4/30/08-general corporate matters	2,609
Period ending 5/31/08-general corporate matters	6,608
Period ending 6/30/08-general corporate matters	923
Period ending 7/31/08 and 8/30/08-general corporate matters	2,546
Period ending 9/30/08-general corporate matters	837
Period ending 10/31/08-general corporate matters	5,272
Period ending 11/30/08-general corporate matters	5,098
Period ending 12/31/08-general corporate matters	3,733
	<hr/>
	31,404

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

Title: Alzheimer's, Memory and Dementia  
Sponsored by: Institute for Natural Resources  
Attended by: Charles Keigley, Administrator  
Date: 4/24/08  
Location: Springfield, IL  
Justification: continuing education  
Cost: 79.00

Title: 2008 Spring IDMA Workshop/Keys to Success in the Future With DMA  
Sponsored by: Central District DMA  
Attended by: Dana Kolb, Food Service Manager  
Date: 4/25/08  
Location: Clinton, IL  
Justification: continuing education  
Cost: 60.00

Title: Best Friends Approach/Train the Trainer Program  
Sponsored by: Community Link  
Attended by: Kathy Altgibbers, QMRP  
Date: 4/9-4/10/08  
Location: Breese, IL  
Justification: Alzheimer's education  
Cost: 70.00

Title: Dietary Managers Conference  
Sponsored by: Dietary's Manager Association  
Attended by: Dana Kolb, Food Service Manager  
Date: 7/11/08  
Location: Clinton, IL  
Justification: Continuing education  
Cost: 132.00

Title: Making It Work On a Dime  
Sponsored by: Illinois Dietary's Manager Association  
Attended by: Dana Kolb, Food Service Manager  
Date: 10/2-10/3/08  
Location: Springfield, IL  
Justification: Continuing education  
Cost: 75.00

Title: Director of Nurses' Fall Conference  
Sponsored by: Director of Nurses' Association of St. Clair County  
Attended by: Pam Woodward, Director of Nurses and Charles Keigley, Administrator  
Date: 10/8/08  
Location: Fairview Heights, IL  
Justification: To attend educational sessions on nursing services  
Cost: 150.00

Title: 13th Annual Conference on Alzheimer Diseases for Professionals:  
Synchronizing Science and Support  
Sponsored by: SIU School of Medicine  
Attended by: Charles Keigley, Administrator  
Date: 11/14/08

Location: Springfield, IL  
Justification: To attend educational sessions on Alzheimer's disease  
Cost: 111.00

Title: Illinois Health Care Association Annual Convention and Trade Show  
Sponsored by: Illinois Health Care Association  
Attended by: Kelly Staebel, QMRP, Kathy Altgibbers, QMRP, Krystal Gruenenfelder, Activity Director, Dana Kolb, Food Service Manager and Diane Van, Administrator on Duty  
Date: 9/4-9/6/08  
Location: Peoria, IL  
Justification: To attend educational sessions relating to the care of the developmentally disabled adult  
Cost: 1,424.

Title: Provider Expo  
Sponsored by: Illinois Health Care Association  
Attended by: Atayna House, Social Services  
Date: 11/1/2008  
Location: Chicago, IL  
Justification: To attend educational sessions relating to the care of the developmentally disabled adult  
Cost: 154.