

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

0026773 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	34,817			34,817	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,817			34,817	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.39%

D. How many bed-hold days during this year were paid by the Department? 404 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

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

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01/09 Fiscal Year: 12/31/09

* 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: 01/01/09 Ending: 12/31/09

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
	A. General Services										
1	Dietary	221,771	20,401	8,444	250,616		250,616		250,616		1
2	Food Purchase		171,696		171,696		171,696		171,696		2
3	Housekeeping	72,331	19,356	11,140	102,827		102,827		102,827		3
4	Laundry			10,447	10,447		10,447		10,447		4
5	Heat and Other Utilities			143,090	143,090		143,090		143,090		5
6	Maintenance	58,885	8,039	20,778	87,702		87,702		87,702		6
7	Other (specify):*										7
8	TOTAL General Services	352,987	219,492	193,899	766,378		766,378		766,378		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,293,925	83,370	74,452	2,451,747		2,451,747		2,451,747		10
10a	Therapy	21,250			21,250		21,250		21,250		10a
11	Activities	45,558	13,726		59,284	2,400	61,684		61,684		11
12	Social Services	30,207		1,560	31,767		31,767		31,767		12
13	CNA Training	8,639			8,639		8,639		8,639		13
14	Program Transportation		16,541		16,541		16,541		16,541		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,399,579	113,637	76,012	2,589,228	2,400	2,591,628		2,591,628		16
	C. General Administration										
17	Administrative	65,108		6,156	71,264	(6,156)	65,108		65,108		17
18	Directors Fees										18
19	Professional Services			57,800	57,800		57,800		57,800		19
20	Dues, Fees, Subscriptions & Promotions			9,182	9,182	1,140	10,322	(1,645)	8,677		20
21	Clerical & General Office Expenses	141,951	10,972	21,122	174,045		174,045		174,045		21
22	Employee Benefits & Payroll Taxes			593,277	593,277	(720)	592,557		592,557		22
23	Inservice Training & Education			5,163	5,163	(350)	4,813		4,813		23
24	Travel and Seminar			4,322	4,322	(118)	4,204		4,204		24
25	Other Admin. Staff Transportation					118	118		118		25
26	Insurance-Prop.Liab.Malpractice			60,414	60,414		60,414		60,414		26
27	Other (specify):* misc. exp.					247	247		247		27
28	TOTAL General Administration	207,059	10,972	757,436	975,467	(5,839)	969,628	(1,645)	967,983		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,959,625	344,101	1,027,347	4,331,073	(3,439)	4,327,634	(1,645)	4,325,989		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			188,899	188,899		188,899		188,899			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Interest & Loan origin. fees for sprinkler loan			2,717	2,717	3,439	6,156		6,156			36
37	TOTAL Ownership			191,616	191,616	3,439	195,055		195,055			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			254,435	254,435		254,435		254,435			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			254,435	254,435		254,435		254,435			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,959,625	344,101	1,473,398	4,777,124		4,777,124	(1,645)	4,775,479			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,575)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,575)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,575)		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.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Parents & Friends of the Specialized Living Center

ID# 0026773

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parents & Friends of the Specialized Living Center# 0026773

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parents & Friends of the Specialized Living Center# 0026773

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Parents and Friends of the CIS	Belleville	SLC Enrichment	Swansea	To provide recreational opportunities to developmentally disabled adults

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	Gymnasium Rental	\$ 2,400	SLC Enrichment Center	n/a	\$ 5,781	\$ 3,381	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,400			\$ 5,781	\$ *	3,381 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: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Community First Bank		X	Construction Line (not complete)	interest only	06/15/09	\$ 271,211	\$ 271,211	03/15/10	0.0500	\$ 1,415	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Community First Bank		X	Line of Credit	none	03/15/2009	as needed			0.0525	302	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 271,211	\$ 271,211			\$ 1,717	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 271,211	\$ 271,211			\$ 1,717	15							

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Patient Care</u>		<u>1979</u>	<u>\$ 999</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 999	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 1,689,315	4
5			1984	1984	303,400	10,133	30	10,133		253,681	5
6			1984	1984	33,537		15			33,537	6
7											7
8											8
	Improvement Type**										
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 Buidling		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 Buidling		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 Saffery/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	\$ 110,133		\$ 110,133	\$	\$ 2,201,601	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0026773

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Totals from Page 12A, Carried Forward		\$ 3,562,005	\$ 110,113		\$ 110,113	\$	\$ 2,201,601	37
38	Water Heaters-Pods 2 and 4	1993	5,491		10			5,491	38
39	A/C Unit-Pod 2 (unit 1)	1993	3,642		10			3,642	39
40	Window Replacements (Pods)	1994	400		10			400	40
41	Painted all pods-labor/materials	1994	10,644		5			10,644	41
42	Additional Smoke Detectors	1994	575		10			575	42
43	Various Corrections fo Coade	1994	1,097		10			1,097	43
44	Water Heater-Pod 5 (booster)	1994	860		10			860	44
45	Water Heater-Pod 6	1995	1,950		10			1,950	45
46	A/C Unit-Pod 6 (unit 2)	1995	3,953		10			3,953	46
47	A/C Unite-ERC	1996	1,774		10			1,774	47
48	Carpeting-all pods	1996	38,806		7			38,806	48
49	Painted Pods-touched up (Labor and Material)	1996	3,356		5			3,356	49
50	Water Heater-Pod 5 (booster)	1996	2,032		10			2,032	50
51	Booster Heater-Pod 5	1996	951		10			951	51
52	Booster Heater (spare)	1997	952		10			952	52
53	Carpeting-Core Building	1997	6,041		7			6,041	53
54	Water Heater-Booster-Dieatry	1997	1,585		7			1,585	54
55	Walk In Freezer Repairs	1998	1,590		7			1,590	55
56	Water Heater-120 gallon	1998	2,152		7			2,152	56
57	Water Heater-120 Gallon	2000	2,256		7			2,256	57
58	Gym Roof	2000	21,635	1,440	15	1,440		13,143	58
59	Renovation of Pod 2	2001	66,904		7			66,904	59
60	Renovation of Pod 4	2001	7,746		7			7,746	60
61	Fire Supression System-Dietary	2002	2,740	359	7	359		2,740	61
62	Water Softener System	2004	1,960	280	7	280		1,680	62
63	Condensing Unit (3 1/2 ton)	2004	742	106	7	106		583	63
64	A/C Unit-Pod 2 (Unit 1)	2004	4,261	609	7	609		3,298	64
65	A/C Compressor Unit-Core Building	2004	14,839	2,120	7	2,120		11,482	65
66	Cabinets in Pod 3	2006	812	81	10	81		318	66
67	Flooring in Pods and Nurses' Office	2006	55,833	3,722	15	3,722		13,338	67
68	Carpet Squares in Pods	2006	2,298	460	5	460		1,648	68
69	Parking Lot gravel-ERC	1985	1,247		10			1,247	69
70	TOTAL (lines 4 thru 69)		\$ 3,833,129	\$ 119,290		\$ 119,290	\$	\$ 2,415,835	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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		\$ 3,833,129	\$ 119,290		\$ 119,290	\$	\$ 2,415,835	37
38	1985	564	19	30	19		438	38
39	2007	5,431	272	20	272		815	39
40	2007	49,890	9,960	5	9,960		21,580	40
41	2008	10,700	1,070	10	1,070		2,051	41
42	2008	4,843	969	5	969		1,776	42
43	2008	3,296	471	10	471		718	43
44	2008	46,873	2,344	20	2,344		3,178	44
45	2008	1,450	195	10	195		309	45
46	2008	914	91	10	91		145	46
47	2008	3,398	170	20	170		269	47
48	2008	6,253	625	10	625		990	48
49	2008	2,636	264	10	264		395	49
50	2008	2,953	591	5	591		640	50
51	2008	4,370	437	10	437		583	51
52	2008	24,968	4,994	5	4,994		5,825	52
53	2008	3,802	380	10	380		412	53
54	2008	1,517	152	10	152		164	54
55	2008	1,453	143	10	143		155	55
56	2008	3,002	3,002		3,002		3,002	56
57	2009	6,000	150	20	150		150	57
58	2009	11,925	288	10	288		288	58
59	2009	266,850		20				59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 4,296,217	\$ 145,877		\$ 145,877	\$	\$ 2,459,718	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 246,676	\$ 30,923	\$ 30,923	\$	5	\$ 147,181	71
72	Current Year Purchases	11,806	879	879		5	879	72
73	Fully Depreciated Assets	453,248	832	832		5	453,248	73
74								74
75	TOTALS	\$ 711,730	\$ 32,634	\$ 32,634	\$		\$ 601,308	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	Dodge Ram Van	2006	\$ 8,645	\$ 1,729	\$ 1,729	\$	5	\$ 5,619	76
77	Patient Care	2006 Dodge Caravan	2006	39,405	7,881	7,881		5	24,300	77
78	Patient Care	Transmission overhaul	2007	3,477	778	778		5	2,342	78
79										79
80	TOTALS			\$ 51,527	\$ 10,388	\$ 10,388	\$		\$ 32,261	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)	\$ 5,175,531	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 188,899	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 188,899	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,209,344	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	Fully Depreciated Vehicles	\$ 116,057	\$	\$ 116,057	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 116,057	\$	\$ 116,057	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 <u>40</u></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>90</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		350		350
3	Classroom Wages (a)		14,560		14,560
4	Clinical Wages (b)		36,160		36,160
5	In-House Trainer Wages (c)		1,588		1,588
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 52,658	\$	\$ 52,658
10	SUM OF line 9, col. 1 and 2 (e)	\$	52,658		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

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

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

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

	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	130 visits	6,559				130	6,559	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 6,559		\$		130	\$ 6,559	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 635,002	\$ 635,002	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,981,523	1,981,523	3
4	Supply Inventory (priced at)	6,481	6,481	4
5	Short-Term Investments			5
6	Prepaid Insurance	18,300	18,300	6
7	Other Prepaid Expenses	11,886	11,886	7
8	Accounts Receivable (owners or related parties)	8,009	8,009	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,661,201	\$ 2,661,201	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,296,217	4,296,217	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	878,938	878,938	16
17	Accumulated Depreciation (book methods)	(3,209,344)	(3,209,344)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,965,811	\$ 1,965,811	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,627,012	\$ 4,627,012	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 701,708	\$ 701,708	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	271,211	271,211	29
30	Accrued Salaries Payable	299,702	299,702	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,388	23,388	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Accounting Fees</u>	11,406	11,406	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,307,415	\$ 1,307,415	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,307,415	\$ 1,307,415	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,319,597	\$ 3,319,597	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,627,012	\$ 4,627,012	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,385,542	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,385,542	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(65,945)	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)	\$ (65,945)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,319,597	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Parents & Friends of the Specialized Living Center # 0026773** Report Period Beginning: **01/01/09**Ending: **12/31/09****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,693,086	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,693,086	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,560	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,560	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	745	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 745	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>garnishment service charges</u>	2,788	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,788	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,711,179	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	766,378	31
32	Health Care	2,589,228	32
33	General Administration	975,467	33
B. Capital Expense			
34	Ownership	191,616	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	254,435	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,777,124	40
41	Income before Income Taxes (line 30 minus line 40)**	(65,945)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (65,945)	43

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,965	2,122	\$ 59,099	\$ 27.85	1
2	Assistant Director of Nursing	1,933	2,107	41,398	19.65	2
3	Registered Nurses					3
4	Licensed Practical Nurses	17,981	19,510	336,179	17.23	4
5	CNAs & Orderlies					5
6	CNA Trainees	6,167	6,174	50,720	8.22	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,026	2,090	20,997	10.05	8
9	Activity Director	1,946	2,120	29,067	13.71	9
10	Activity Assistants	1,636	1,645	15,275	9.29	10
11	Social Service Workers	1,949	2,117	30,539	14.43	11
12	Dietician					12
13	Food Service Supervisor	3,801	4,247	60,794	14.31	13
14	Head Cook	3,528	3,872	39,281	10.14	14
15	Cook Helpers/Assistants	722	722	6,776	9.39	15
16	Dishwashers	11,997	12,839	111,235	8.66	16
17	Maintenance Workers	4,282	4,702	57,484	12.23	17
18	Housekeepers	5,787	6,756	74,634	11.05	18
19	Laundry					19
20	Administrator	1,903	2,080	65,108	31.30	20
21	Assistant Administrator					21
22	Other Administrative	3,575	4,236	83,203	19.64	22
23	Office Manager	1,532	1,900	40,985	21.57	23
24	Clerical	1,832	2,060	23,270	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,415	9,446	148,765	15.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	151,025	164,866	1,658,285	10.06	30
31	Medical Records	326	366	3,627	9.91	31
32	Other Health C: Training Coord.	576	638	11,886	18.63	32
33	Other(specify) <u>Seamstress</u>	1,206	1,262	10,677	8.46	33
34	TOTAL (lines 1 - 33)	236,110	257,877	\$ 2,979,284 *	\$ 11.55	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	86	\$ 3,927		35
36	Medical Director	96	14,500		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	41	1,025		39
40	Physical Therapy Consultant	49	2,445		40
41	Occupational Therapy Consultant	131	6,550		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	95	5,700		43
44	Activity Consultant				44
45	Social Service Consultant	25	1,560		45
46	Other(specify) <u>Psychologist</u>	306	20,238		46
47	<u>Psychiatrist</u>	33	3,330		47
48					48
49	TOTAL (lines 35 - 48)	862	\$ 59,275		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	448	14,105		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	448	\$ 14,105		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Charles K. Keigley	Administrator	0	\$ 65,108	Workers' Compensation Insurance	\$ 41,630	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,268	Advertising: Employee Recruitment	2,933	
				FICA Taxes	234,840	Health Care Worker Background Check	720	
				Employee Health Insurance	225,288	(Indicate # of checks performed <u>24</u>)		
				Employee Meals	69,344	<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Assoc. dues	5,413	
				Employee Physicals	2,398	less IHCA lobbying costs	(1,509)	
				Employee Gift/Relations	4,046	Licensing Fees & Annual Report	885	
				Employer Matching 403B Contribution	2,139	Dietary Manager's Association	135	
				Employee Life & Disability Insurance	9,604	Illinois Nursing Home Administrator Assoc.	100	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 592,557	\$ 8,677		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Interest Expense							Out-of-State Travel	
\$ 1,717							\$	
Loan Origination Fees - Sprinkler Loan								
4,439							In-State Travel	
							1,331	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 6,156				\$			2,873	
C. Professional Services								
Vendor/Payee							Entertainment Expense	
Type							()	
Amount							(agree to Sch. V, line 24, col. 8)	
Duane Morris, LLP							TOTAL	
Legal							\$ 4,204	
26,048								
Thomas Kennedy, III, LC								
Legal								
1,500								
Gallop, Johnson & Newman								
Legal								
11,941								
Evans Law Firm								
Legal								
1,663								
LarsonAllen LLP								
Audit Services								
11,457								
SIDC								
Payroll Services								
5,191								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 57,800								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning: 01/01/09

Ending: 12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes - Hab Techs only
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Health Care Association -\$5244
- (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? yes
- (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. \$ 26,533 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 254,435
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. \$ 65,704 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 99
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Larson Allen LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

**Parents and Friends of the SLC
 Cost Report Attachment 2
 Schedule V Reclassifications**

Description	Line #s	Healthcare & Programs	General Admin.	Ownership
Enrichment Center Monthly Fees (see sch. VII)	11&36	2,400		(2,400)
Interest Expense	17&36		(1,717)	1,717
Loan origination fees (Sprinkler System)	17&36		(4,439)	4,439
Employee Background Checks	20		720	
Employee Background Checks	22		(720)	
Sam's Club Membership	20		70	
Food Service Sanitation Certificates	20		350	
Food Service Sanitation Certificates	23		(350)	
Amtrack Ticket (Vehicle Grants Meeting)	24		(118)	
Amtrack Ticket (Vehicle Grants Meeting)	25		118	
Misc. Expense	27		247	
Sams Club Membership & Other misc.	36			(317)
		2,400	(5,839)	3,439

**Parents and Friends of the SLC
 Cost Report Attachment 3
 Schedule V Line 23, 24 & 25 Costs**

Line 23 - Inservice Training & Education

American Red Cross Rentals	2,332
Crisis Prevention Institute Training Manuals	2,481
Total Line 23	<u>4,813</u>

Line 24 - Travel & Seminar

	Date	Seminar Expense	In-State Travel		
			Hotels	Gasoline	Total
Food Sanitation Course	01/09	750			
Refresher Food Sanitation Course	02/09	75			
Crisis Prevention Institute	07/09	943			
IHCA New Quality of Life Revision to LTC Surveyors Guidance State Specific	07/14	190			
IHCA Convention & Trade Show	09/14 - 9/17	795	1,052	279	1,331
LTC DON of Metro East	10/14	120			
Total Line	<u>4,204</u>	<u>2,873</u>			<u>1,331</u>

Line 25 -Other Admin. Staff Transportation

Amtrack ticket to/from vehicle grant meeting	118
Total Line 25	<u>118</u>

Parents and Friends of the Specialized Living Center
IDPHID# 0026773
01/01/09 - 12/31/09

Board Members:

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

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