

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

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

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,593	61		35,654	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,593	61		35,654	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.68%

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

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Parents & Friends of the Specialized Living C

0026773

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	200,907	15,872	9,827	226,606		226,606	226,606			1
2	Food Purchase		151,033		151,033		151,033	151,033			2
3	Housekeeping	25,416	18,249	6,851	50,516		50,516	50,516			3
4	Laundry		4,200		4,200		4,200	4,200			4
5	Heat and Other Utilities			103,406	103,406		103,406	103,406			5
6	Maintenance	50,457	7,981	34,823	93,261		93,261	93,261			6
7	Other (specify):*										7
8	TOTAL General Services	276,780	197,335	154,907	629,022		629,022	629,022			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,463,340	90,834	66,968	2,621,142		2,621,142	2,621,142			10
10a	Therapy	19,818			19,818		19,818	19,818			10a
11	Activities	50,133	13,617		63,750	2,304	66,054	66,054			11
12	Social Services	19,022		1,440	20,462		20,462	20,462			12
13	CNA Training	11,861			11,861		11,861	11,861			13
14	Program Transportation		14,285		14,285		14,285	14,285			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,564,174	118,736	68,408	2,751,318	2,304	2,753,622	2,753,622			16
	C. General Administration										
17	Administrative	54,050		11,172	65,222	(11,015)	54,207	54,207			17
18	Directors Fees										18
19	Professional Services			32,073	32,073		32,073	32,073			19
20	Dues, Fees, Subscriptions & Promotions			6,240	6,240	796	7,036	5,024			20
21	Clerical & General Office Expenses	148,869	10,322	20,818	180,009		180,009	180,009			21
22	Employee Benefits & Payroll Taxes			634,545	634,545	(700)	633,845	633,845			22
23	Inservice Training & Education			2,498	2,498		2,498	2,498			23
24	Travel and Seminar			1,492	1,492		1,492	1,492			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			84,378	84,378		84,378	84,378			26
27	Other (specify):*										27
28	TOTAL General Administration	202,919	10,322	793,216	1,006,457	(10,919)	995,538	993,526			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,043,873	326,393	1,016,531	4,386,797	(8,615)	4,378,182	4,376,170			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 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	
	D. Ownership											
30	Depreciation			228,735	228,735		228,735		228,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					11,015	11,015		11,015			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			14,900	14,900	(2,400)	12,500	(12,500)				36
37	TOTAL Ownership			243,635	243,635	8,615	252,250	(12,500)	239,750			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			288,744	288,744		288,744		288,744			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			288,744	288,744		288,744		288,744			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,043,873	326,393	1,548,910	4,919,176		4,919,176	(14,512)	4,904,664			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	(2,012)	20		17
18	Fines and Penalties	(12,500)	36		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,512)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	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)	\$ (14,512)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Parents & Friends of the Specialized Living Center

ID# 0026773

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

01/01/12

Ending:

12/31/12

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	(2,012)	0	0	0	0	0	0	0	0	0	0	(2,012)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,012)	0	0	0	0	0	0	0	0	0	0	(2,012)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,012)	0	0	0	0	0	0	0	0	0	0	(2,012)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/12 Ending:12/31/12

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):*	(12,500)	0	0	0	0	0	0	0	0	0	0	(12,500)	36
37	TOTAL Ownership	(12,500)	0	0	0	0	0	0	0	0	0	0	(12,500)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(14,512)	0	0	0	0	0	0	0	0	0	0	(14,512)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				SLC Enrichment Cent	Swansea	To provide recreational oppoprunities 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	Gymnasium Rental	2,400			2,400		2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,400			\$ 2,400	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 01/01/12 Ending: 12/31/12

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

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	Community First Bank		X	Line of Credit	Interest Only	03/15/12	as needed	zero	04/15/13	0.0525	11,015					
7																
8																
9	TOTAL Facility Related						\$	\$			\$ 11,015					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$ 11,015					

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 report.		\$	N/A		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$	N/A		3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	N/A		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007 _____	8	FOR BHF USE ONLY			
	2008 _____	9				
	2009 _____	10				
	2010 _____	11				
	2011 _____	12				
			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
			14	PLUS APPEAL COST FROM LINE 5	\$	14
			15	LESS REFUND FROM LINE 6	\$	15
			16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 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 2011 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 2011.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 fram 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:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 2,999,001	\$ 100,000	30	\$ 100,000	\$	\$ 1,989,315	4
5		1984	1984	303,400	10,113	30	10,113		284,021	5
6		1984	1984	33,537		15			33,537	6
7										7
8										8
	Improvement Type**									
9	Renovation of Pod 2		2001	22,806					22,806	9
10	Doors- ERC		1985	564	19	30	19		513	10
11	Fire Suppression System (Dietary)		2003	2,740		7			2,740	11
12	Water Centers (Schaeffer)		2004	1,960		7			1,960	12
13	Belo - Sales and Service		2004	4,261		7			4,261	13
14	Belo - Sales and Service		2004	14,839		7			14,839	14
15	Flooring in Houses' and Nurses offices		2006	55,833	3,722	15	3,722		24,504	15
16	Carpet squares/ Houses living room		2006	2,298		5			2,298	16
17	Fire Alarm Control Panel		2007	5,431	272	20	272		1,629	17
18	Painting of 2 houses		2007	49,800	8,300	5	8,300		49,800	18
19	blinds in houses		2008	10,700	1,070	10	1,070		5,260	19
20	Water heater/120gal and install		2008	4,843	969	5	969		4,682	20
21	Door frames (6) (Overhead Door)		2008	3,296	471	7	471		2,131	21
22	Core Building Roof		2008	46,873	2,344	20	2,344		10,209	22
23	replacement of fire alarm panel		2008	3,398	170	20	170		779	23
24	replace 7.5 ton A/C unit (House 6)		2008	6,253	625	10	625		2,866	24
25	A/C replacements House 3		2008	2,636	264	10	264		1,186	25
26	Booster Water Heater (House 5)		2008	2,953	591	5	591		2,412	26
27	Squirrel Cage for House 6		2008	4,370	437	10	437		1,894	27
28	Roof Repairs Houses 2,4,5 & 6		2008	24,968	4,994	5	4,994		20,807	28
29	Starter Assemblies 2,4,5 & 6		2008	3,802	380	10	380		1,552	29
30	Freezer Floor		2009	11,536	1,154	10	1,154		3,749	30
31	Sprinkler System		2010	515,800	25,790	20	25,790		60,497	31
32	Fire alarm upgrade		2010	22,426	1,121	20	1,121		2,646	32
33	Core Building Roof Repairs		2010	3,212	161	10	161		415	33
34	Sidewalks		2010	21,075	2,108	10	2,108		6,763	34
35	Pod 2 Air Conditioner		2012	6,200	1,033	5	1,033		1,033	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,190,811	\$ 166,105		\$ 166,105	\$	\$ 2,561,104	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 163,496	\$ 8,275	\$ 8,275	\$		\$ 120,990	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	131,343	25,286	25,286			131,343	73
74								74
75	TOTALS	\$ 294,839	\$ 33,561	\$ 33,561	\$		\$ 252,333	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	various	various	\$ 39,881	\$	\$	\$	5	\$ 39,881	76
77	Patient Care	Dodge Caravan Van	2006	39,405				5	39,405	77
78	Patient Care	Kia Sadonas (#3)	2011	63,285	12,657	12,657		5	16,876	78
79	Patient Care	Wheelchair Vans (#2)	2011	82,057	16,412	16,412		5	20,515	79
80	TOTALS			\$ 224,628	\$ 29,069	\$ 29,069	\$		\$ 116,677	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,711,277	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 228,735	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 228,735	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,930,114	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/12 Ending: 12/31/12
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>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		775		775
3	Classroom Wages (a)		9,814		9,814
4	Clinical Wages (b)		23,125		23,125
5	In-House Trainer Wages (c)		2,626		2,626
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 36,340	\$	\$ 36,340
10	SUM OF line 9, col. 1 and 2 (e)	\$	36,340		

- (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.

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	31
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	31

- (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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	Line 10/Column 3	131 visits	7,211				131	7,211	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 7,211		\$	\$	131	\$ 7,211	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# 0026773Report Period Beginning: 01/01/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(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	\$ 650,313	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,225,402		3
4	Supply Inventory (priced at)	8,222		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	65,547		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,949,483	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,191,810		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	519,467		16
17	Accumulated Depreciation (book methods)	(2,930,114)		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)	\$ 1,781,163	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,730,646	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 242,687	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	320,800		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,712		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 588,199	\$	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)	\$ 588,199	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,142,447	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,730,646	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,234,298	1
2	Restatements (describe):		2
3	Desk audit of capital cost	(11,556)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,222,742	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(80,295)	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)	\$ (80,295)	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)	\$ 3,142,447	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,796,823	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,796,823	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	36,340	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)	\$ 36,340	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,206	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,206	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Garnishment Service Charges/Restitution	1,509	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,509	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,838,878	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	629,021	31
32	Health Care	2,751,317	32
33	General Administration	1,006,457	33
B. Capital Expense			
34	Ownership	243,634	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	288,744	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,919,173	40
41	Income before Income Taxes (line 30 minus line 40)**	(80,295)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (80,295)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,046,644	44
45	Private Pay - Net Inpatient Revenue	9,000	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Cost of Care</u>	734,047	47
48	Other-(specify) <u>Work Recoupement</u>	7,132	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,796,823	49

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning: 01/01/12

Ending: 12/31/12

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	1,784	2,015	\$ 48,951	\$ 24.29	1
2	Assistant Director of Nursing	1,832	2,069	38,418	18.57	2
3	Registered Nurses	436	436	7,332	16.82	3
4	Licensed Practical Nurses	17,694	19,154	338,602	17.68	4
5	CNAs & Orderlies					5
6	CNA Trainees	9,795	9,995	88,738	8.88	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,730	1,952	19,818	10.15	8
9	Activity Director	812	1,100	20,115	18.29	9
10	Activity Assistants	2,992	3,297	30,017	9.10	10
11	Social Service Workers	1,040	1,040	19,022	18.29	11
12	Dietician					12
13	Food Service Supervisor	3,177	3,619	48,198	13.32	13
14	Head Cook	5,398	6,081	65,927	10.84	14
15	Cook Helpers/Assistants					15
16	Dishwashers	8,986	9,964	86,592	8.69	16
17	Maintenance Workers	3,822	4,256	50,457	11.86	17
18	Housekeepers	2,317	2,542	25,416	10.00	18
19	Laundry					19
20	Administrator	1,926	2,080	54,050	25.99	20
21	Assistant Administrator					21
22	Other Administrative	3,654	4,240	80,010	18.87	22
23	Office Manager	983	1,317	26,458	20.09	23
24	Clerical	1,805	2,082	23,653	11.36	24
25	Vocational Instruction					25
26	Academic Instruction	621	621	11,861	19.10	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,826	11,028	186,498	16.91	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	141,739	158,622	1,608,433	10.14	30
31	Medical Records					31
32	Other Health C: AOD	10,419	11,546	156,212	13.53	32
33	Other(specify) <u>Seamstress</u>	946	1,117	9,095	8.14	33
34	TOTAL (lines 1 - 33)	233,734	260,173	\$ 3,043,873 *	\$ 11.70	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	209	\$ 9,827	35
36	Medical Director	112	16,800	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	12	1,200	39
40	Physical Therapy Consultant	28	1,388	40
41	Occupational Therapy Consultant	154	7,675	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	100	5,960	43
44	Activity Consultant			44
45	Social Service Consultant	24	1,440	45
46	Other(specify) <u>Psychologist</u>	313	21,894	46
47	<u>Psychiatrist</u>	48	4,840	47
48				48
49	TOTAL (lines 35 - 48)	1,000	\$ 71,024	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

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	
<u>Karelene Dotson</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 54,050</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 81,190</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>11,662</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>228,654</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>196,002</u>	<u>(Indicate # of checks performed <u>35</u>)</u>	<u>700</u>	
				<u>Employee Meals</u>	<u>101,983</u>	<u>Patient Background Checks</u>	<u>6</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Health Care Assoc. Dues</u>	<u>3,437</u>	
				<u>Employee Physicals</u>	<u>304</u>	<u>Licensing Fees</u>	<u>406</u>	
				<u>Employee Gift/Relations</u>	<u>3,435</u>	<u>HPSI dues</u>	<u>175</u>	
				<u>Employer Matching 403B Contribution</u>	<u>994</u>	<u>SAM's Club Membership</u>	<u>210</u>	
				<u>Employee Life & Disability Insurance</u>	<u>9,621</u>			
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 54,050	TOTAL (agree to Schedule V, line 22, col.8)	\$ 633,845	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,024	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Fines</u>			<u>\$ 12,500</u>	<u>N/A</u>		<u>\$</u>	<u>Out-of-State Travel</u>	<u>\$</u>
<u>Gymansim Rental Fee</u>			<u>2,400</u>					
							<u>In-State Travel</u>	<u>397</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 14,900				<u>Seminar Expense</u>	<u>795</u>
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				()	
<u>Evans Law Firm</u>	<u>Legal</u>		<u>\$ 3,683</u>					
<u>The Lowenbaum Partnership</u>	<u>Legal</u>		<u>11,914</u>					
<u>Sorling, Nothrup</u>	<u>Legal</u>		<u>1,535</u>					
<u>SIDC Payroll Services</u>	<u>Payroll Services</u>		<u>5,401</u>					
<u>Clifton Larson Allen, LLC</u>	<u>Financial Audit Services</u>		<u>9,540</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 32,073	\$			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 1,192	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0026773

Report Period Beginning:

01/01/12

Ending:

12/31/12

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes - Hab Techs only
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Health Care Association - \$3,437
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,296 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 288,744
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. \$ 98,820 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 99%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Clifton Larson Allen LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

**Parents and Friends of the SLC
 Cost Report Attachment 1
 Schedule V Line 23 & 24**

Line 23 - Inservice Training & Education

American Red Cross Rentals	966	
J.A. Logan College	42	
University of Florida Flexible Learning	650	Food Service Management
Study Materials	840	

Total Line 23 2,498

Line 24 - Travel & Seminar

	<u>Date</u>	<u>Registration Fee</u>	<u>Hotel</u>	<u>Gasoline</u>	<u>Meals</u>	<u>Total</u>
IHCA Convention & Trade Show	Sept. 13,14 &15	795	265	50	82	1,192
IHCA Electronic Records	5/30/2012	95				95
LTC- DON Annual Fall Conference	10/10/2012	130				130
Illinois NAFP	10/4/2012	75				75

Total Line 24 1,492

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

Schedule V Reclassifications	Description
Activity Other (96)	Patient Background checks
Activity Other 2,400	Gym Rental Fee
Administrative Other (11,015)	Interest expense
Dues/Subscriptions 796	+700 Employee Backgroup Checks/+96 Patient Background checks
Clerical/General Office -	Office Supplies
Employee Benefits (700)	-1,055 Employee Background Checks/-21 Patient Background checks
Interest 11,015	Interest expense
Other (2,400)	-2,400 Gym Rental Fee
<u>Net Adjustments -</u>	

Parents and Friends of the Specialized Living Center
Cost Report Attachment 3
IDPHID# 0026773
01/01/12 - 12/31/12

Board Members:

Orville Lester
Arland Lester
Donna Harris
Wilma Postin
Agnes Schloeman
Rev. Dr. WJ Griffin

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

**Parents and Friends of the Specialized Living Center
Cost Report Attachment 4
Page 19 Supplementary Schedule**

Line 25 - Interest and other investment income

4,206.00 Bank interest - Unrestricted

4,206.00 Total