FOR BHF USE

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0019166

Facility Name: Pleasant Meadows Christian Village

Address: 400 West Washington (Number) Chrisman (City) 61924 (Zip Code)

County: Edgar

Telephone Number: 217-269-2396 **Fax #** 217-269-2603

HFS ID Number:

Date of Initial License for Current Owners: 1974

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Susan Mcghee **Telephone Number:** 314-587-7903
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/09 to 6/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Tim Phillippe
(Title) Chief Executive Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Allan B. Larson, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington Ave, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4379 Fax # 314-925-4350

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,064	7,337	5,254	32,655	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,064	7,337	5,254	32,655	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.08%

D. How many bed-hold days during this year were paid by the Department?
None (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)
None

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 1974

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 109 and days of care provided 4,335

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	294,785	21,346	6,843	322,974		322,974		322,974			1
2	Food Purchase		237,100		237,100		237,100	(774)	236,326			2
3	Housekeeping	172,709	26,006	43	198,758		198,758		198,758			3
4	Laundry	17,237	8,319		25,556		25,556		25,556			4
5	Heat and Other Utilities			218,151	218,151		218,151	1,511	219,662			5
6	Maintenance	55,895	19,782	52,031	127,708		127,708	3,381	131,089			6
7	Other (specify):*											7
8	TOTAL General Services	540,626	312,553	277,068	1,130,247		1,130,247	4,118	1,134,365			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,131,090	135,853	35,750	2,302,693		2,302,693		2,302,693			10
10a	Therapy			526,499	526,499		526,499		526,499			10a
11	Activities	83,235			83,235		83,235	(247)	82,988			11
12	Social Services	135,339	1,411	5,554	142,304		142,304		142,304			12
13	CNA Training											13
14	Program Transportation			5,489	5,489		5,489	(235)	5,254			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,349,664	137,264	585,292	3,072,220		3,072,220	(482)	3,071,738			16
	C. General Administration											
17	Administrative	98,684	2,076	374,595	475,355		475,355	(317,943)	157,412			17
18	Directors Fees											18
19	Professional Services			4,473	4,473		4,473	26,390	30,863			19
20	Dues, Fees, Subscriptions & Promotions			50,631	50,631		50,631		50,631			20
21	Clerical & General Office Expenses	151,852	13,953	55,887	221,692		221,692	147,814	369,506			21
22	Employee Benefits & Payroll Taxes			613,393	613,393		613,393	25,438	638,831			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,530	18,530		18,530	12,415	30,945			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,679	86,679		86,679	1,004	87,683			26
27	Other (specify):* Marketing	72,563	1,169	21,949	95,681		95,681	(95,681)				27
28	TOTAL General Administration	323,099	17,198	1,226,137	1,566,434		1,566,434	(200,563)	1,365,871			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,213,389	467,015	2,088,497	5,768,901		5,768,901	(196,927)	5,571,974			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pleasant Meadows Christian Village #0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			189,255	189,255		189,255	16,654	205,909			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,313	13,313		13,313	(7,126)	6,187			32
33	Real Estate Taxes			213	213		213	(213)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,393	30,393		30,393		30,393			35
36	Other (specify):* Other			72	72		72		72			36
37	TOTAL Ownership			233,246	233,246		233,246	9,315	242,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			232,255	232,255		232,255		232,255			39
40	Barber and Beauty Shops	20,028	1,195		21,223		21,223		21,223			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):* Apt/Congregate			34,896	34,896		34,896	(34,896)				43
44	TOTAL Special Cost Centers	20,028	1,195	326,828	348,051		348,051	(34,896)	313,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,233,417	468,210	2,648,571	6,350,198		6,350,198	(222,508)	6,127,690			45

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,155)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,930)	5		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	(13,313)	32		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				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	179	21		24
25	Fund Raising, Advertising and Promotional	(95,681)	27		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	(35,154)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,054)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(72,454)	VII=B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (72,454)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (222,508)		37

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

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

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

STATE OF ILLINOIS

Pleasant Meadows Christian Village

ID# **0019166**

Report Period Beginning: **7/1/09**

Ending: **6/30/10**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 381	2	1
2	Activity	(247)	11	2
3	Transportation	(235)	14	3
4	Miscellaneous	56	21	4
5	Real Estate Taxes for Vacant Lot	(213)	33	5
6	Apartments/Congregate	(34,896)	43	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**	(35,154)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(774)	0	0	0	0	0	0	0	0	0	0	(774)	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	(4,930)	6,441	0	0	0	0	0	0	0	0	0	1,511	5
6	Maintenance	0	3,381	0	0	0	0	0	0	0	0	0	3,381	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,704)	9,822	0	0	0	0	0	0	0	0	0	4,118	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	(247)	0	0	0	0	0	0	0	0	0	0	(247)	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	(235)	0	0	0	0	0	0	0	0	0	0	(235)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(482)	0	0	0	0	0	0	0	0	0	0	(482)	16
	C. General Administration													
17	Administrative	0	(317,943)	0	0	0	0	0	0	0	0	0	(317,943)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	26,390	0	0	0	0	0	0	0	0	0	26,390	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	235	147,579	0	0	0	0	0	0	0	0	0	147,814	21
22	Employee Benefits & Payroll Taxes	0	25,438	0	0	0	0	0	0	0	0	0	25,438	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,415	0	0	0	0	0	0	0	0	0	12,415	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	1,004	0	0	0	0	0	0	0	0	0	1,004	26
27	Other (specify):*	(95,681)	0	0	0	0	0	0	0	0	0	0	(95,681)	27
28	**TOTAL General Administration**	(95,446)	(105,117)	0	0	0	0	0	0	0	0	0	(200,563)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(101,632)	(95,295)	0	0	0	0	0	0	0	0	0	(196,927)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	16,654	0	0	0	0	0	0	0	0	0	16,654	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,313)	6,187	0	0	0	0	0	0	0	0	0	(7,126)	32
33	Real Estate Taxes	(213)	0	0	0	0	0	0	0	0	0	0	(213)	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**	(13,526)	22,841	0	0	0	0	0	0	0	0	0	9,315	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):*	(34,896)	0	0	0	0	0	0	0	0	0	0	(34,896)	43
44	**TOTAL Special Cost Centers**	(34,896)	0	0	0	0	0	0	0	0	0	0	(34,896)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(150,054)	(72,454)	0	0	0	0	0	0	0	0	0	(222,508)	45

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing for Board of Directors						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc. and A	100.00%	$ 6,441	$ 6,441	1
2	V	6	Maintenance				3,381	3,381	2
3	V	17	Adminstrative	374,595			56,652	(317,943)	3
4	V	19	Professional Services				26,390	26,390	4
5	V	21	Clerical				147,579	147,579	5
6	V	22	Employee Benefits				25,438	25,438	6
7	V	26	Insurance				1,004	1,004	7
8	V	30	Depreciation				16,654	16,654	8
9	V	24	Travel and Seminars				12,415	12,415	9
10	V	32	Interest				6,187	6,187	10
11	V								11
12	V								12
13	V								13
14	Total			$ 374,595			$ 302,141	$ * (72,454)	14

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpapaper is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Illinois Finance Authority		X	Renovation Projects		6/30/07	$ 253,780	$ 159,572	6/20/2031	0.0560	$ 13,313	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 253,780	$ 159,572			$ 13,313	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 253,780	$ 159,572			$ 13,313	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

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

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

Facility Name & ID Number Pleasant Meadows Christian Village **#** 0019166 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pleasant Meadows Christian Village COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0019166

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-03-26-400-021	S26 T16 R12	$ 42.00	$
2.	11-03-26-300-014	S26 T16 R12	$ 75.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 117.00	$

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? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,356 B. General Construction Type: Exterior Brick Frame Steel/Wood Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

None

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	Facility	46,356	1971	$ 15,876	1
2	Home Office Allocation			4,611	2
3	TOTALS	46,356		$ 20,487	3

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	109		1975	1975	$ 1,305,939	$ 31,866	40	$ 31,866	$	$ 1,086,115	4
5					228,890		20				5
6					1,235,805	41,194	30	41,194		432,532	6
7											7
8	Home Office Allocation				47,555	3,533		3,533		94,804	8
	Improvement Type**										
9	Improvements			1978	18,615					18,615	9
10	Improvements			1979	3,855	84	46	84		2,605	10
11	Improvements			1980	533	12	44	12		364	11
12	Improvements			1981	597					597	12
13	Improvements			1984	15,129					15,129	13
14	Improvements			1985	4,298					4,298	14
15	Improvements			1986	11,970					11,970	15
16	Improvements			1987	3,368					3,368	16
17	Improvements			1988	31,501					31,501	17
18	Improvements			1989	25,437					25,437	18
19	Improvements			1990	18,466					18,466	19
20	Improvements			1991	31,932	558	various	558		31,400	20
21	Improvements			1992	39,706	536	various	536		38,853	21
22	Improvements			1993	49,260	100	various	100		48,960	22
23	Improvements			1994	38,201	1,254	various	1,254		38,201	23
24	Improvements			1995	32,402					32,402	24
25	Improvements			1996	39,258	220	various	220		31,375	25
26	Improvements			1997	14,200					14,200	26
27	Improvements			1998	18,548	151	various	151		14,339	27
28	Improvements			1999	14,537	85	various	85		12,072	28
29	Improvements			2000	22,123	974	various	974		22,087	29
30	Improvements			2001	19,476	1,461	various	1,461		16,915	30
31	Improvements			2002	27,274	1,637	various	1,637		13,498	31
32	Improvements			2003	29,373	2,611	various	2,611		21,408	32
33	Improvements			2004	9,301	1,757	various	1,757		6,773	33
34	Improvements			2005	28,208	2,281	various	2,281		16,171	34
35	Improvements			2006	17,613	2,990	various	2,990		11,809	35
36	Lomectp Prestige Flooring Installation			2007	9,856	986	10	986		2,793	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Asphalt Repair & Sealing	2007	$ 6,778	$ 848	8	$ 848	$	$ 2,401	37
38	Install 24 shrubs landscape front ar	2007	1,492	149	10	149		398	38
39	65 Gallon Water Heater	2008	6,183	618	10	618		1,237	39
40	Landscaping Project - Pond Construction	2008	7,985	799	10	799		1,930	40
41	Roof Work	2008	4,200	420	10	420		735	41
42	Fire Barrier Life Safety Work	2008	7,652	765	10	765		1,721	42
43	Install 2 New AC Compressors	2008	2,500	250	10	250		521	43
44	Door monitor equipment	2009	5,887	589	10	589		785	44
45	13 handicapped stools with lids	2009	2,445	245	10	245		326	45
46	Install 42x54 glass	2009	515	52	10	52		60	46
47	Install 49x61 glass	2009	615	62	10	62		72	47
48	Install double pane windows residents	2009	17,898	1,342	10	1,342		1,342	48
49	Duro Last Membrane for roof	2009	28,310	2,123	10	2,123		2,123	49
50	Kitchen Door	2009	599	50	10	50		50	50
51	Mag Lock for Haven Center	2010	1,249	31	10	31		31	51
52	Electrical Circuits for Rooftop AC	2010	5,995	100	10	100		100	52
53	Dining/Chapel HVAC & Ductwork	2010	188,788	1,573	10	1,573		1,573	53
54	CMS Survey Compliance	2010	30,923	258	10	258		258	54
55	Asbestos Inspection	2010	6,180	52	10	52		52	55
56	Privacy Curtains	2010	1,538	13	10	13		13	56
57	Electrical Upgrade Material	2010	24,273	202	10	202		202	57
58	Dining Room & Chapel Sheers	2010	10,188	85	10	85		85	58
59	Soffit Work	2010	17,536	146	10	146		146	59
60	Smoke Walls/New Walls	2010	43,752	365	10	365		365	60
61	Door & frame removal and relocation	2010	1,100	9	10	9		9	61
62	Ceiling Installation	2010	56,397	470	10	470		470	62
63	Sprinkler Heads	2010	7,050	59	10	59		59	63
64	Chapel Floor Installation	2010	3,050	25	10	25		25	64
65	Field Drainage	2010	18,500	154	10	154		154	65
66	Remove & replace asbestos in flooring	2010	64,200	535	10	535		535	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,967,004	$ 106,679		$ 106,679	$	$ 2,136,835	70

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 470,922	$ 64,298	$ 64,298	$	various	$ 238,313	71
72	Current Year Purchases	76,251	9,645	9,645		various	9,645	72
73	Fully Depreciated Assets	527,006				various	527,006	73
74	Home Office Allocation	152,458	11,326	11,326			23,198	74
75	TOTALS	$ 1,226,637	$ 85,269	$ 85,269	$		$ 798,162	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 Transportation	1994 Ford Bus	5/25/1994	$ 43,500	$	$	$	8	$ 43,500	76
77	Patient Transportation	2009 Ford E250 Van	1/27/2010	29,744	3,718	3,718		4	3,718	77
78										78
79	Home Office Allocation			24,157	1,795	1,795			8,530	79
80	TOTALS			$ 97,401	$ 5,513	$ 5,513	$		$ 55,748	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)	$ 5,311,529	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 197,461	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 197,461	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)	$ 2,990,745	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	Duplex	$ 96,778	$ 2,078	$ 83,726	86
87	Congregate	444,317	10,238	299,465	87
88	Land	24,818			88
89					89
90					90
91	TOTALS	$ 565,913	$ 12,316	$ 383,191	91

G. Construction-in-Progress

	Description	Cost	
92	HomeOffice Allocation	$ 34,863	92
93			93
94			94
95		$ 34,863	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.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 30,393 Description: See Attached Schedule
(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	N/A		$	$	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.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   The organization was not eligible to teach training at the facility

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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

(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.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

		1	2	3	4	5	6	7	8	
	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	10A-3	hrs	$	1,866	$ 151,442	$	1,866	$ 151,442	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,004	96,929		1,004	96,929	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		3,523	278,128		3,523	278,128	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	6,393	$ 526,499	$	6,393	$ 526,499	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.

STATE OF ILLINOIS

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 790,822	$	1
2	Cash-Patient Deposits	21,785		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,820)	502,190		3
4	Supply Inventory (priced at cost)	16,317		4
5	Short-Term Investments	254,005		5
6	Prepaid Insurance	733		6
7	Other Prepaid Expenses	9,339		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Rec.	9,843		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,605,034	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,694		13
14	Buildings, at Historical Cost	4,402,957		14
15	Leasehold Improvements, at Historical Cost	157,731		15
16	Equipment, at Historical Cost	1,146,181		16
17	Accumulated Depreciation (book methods)	(3,287,734)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,509,054		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,968,883	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,573,917	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 419,186	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,785		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	338,236		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	150		32
33	Accrued Interest Payable	1,436		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Liabilities	39,635		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 820,428	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	159,572		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Affiliate	9,386		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 168,958	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 989,386	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,584,531	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,573,917	$	48

***(See instructions.)**

Facility Name & ID Number Pleasant Meadows Christian Village **#** 0019166 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,798,855	1
2	Restatements (describe):		2
3	**Rounding Difference**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,798,854	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(214,323)	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)**	$ (214,323)	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)**	$ 4,584,531	24 *

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,739,518	1
2	Discounts and Allowances for all Levels	(1,757,336)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,982,182	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,653,511	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,653,511	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,184	13
14	Non-Patient Meals	1,155	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	55,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,620	19
20	Radiology and X-Ray	8,530	20
21	Other Medical Services	17,683	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 134,418	23
	D. Non-Operating Revenue		
24	Contributions	91,097	24
25	Interest and Other Investment Income***	48,279	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 139,376	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Apartment/Duplex	164,299	28
28a	Gain/Loss on Investments and Misc Income	62,089	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 226,388	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,135,875	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,130,247	31
32	Health Care	3,072,220	32
33	General Administration	1,566,434	33
	B. Capital Expense		
34	Ownership	233,246	34
	C. Ancillary Expense		
35	Special Cost Centers	288,374	35
36	Provider Participation Fee	59,677	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,350,198	40
41	**Income before Income Taxes (line 30 minus line 40)****	(214,323)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (214,323)	43

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

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

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

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,123	2,123	$ 91,163	$ 42.94	1
2	Assistant Director of Nursing	3,328	3,328	125,627	37.75	2
3	Registered Nurses	11,581	12,818	348,391	27.18	3
4	Licensed Practical Nurses	23,636	25,308	487,981	19.28	4
5	CNAs & Orderlies	73,787	81,785	855,364	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,026	4,026	46,977	11.67	8
9	Activity Director	1,818	1,818	19,459	10.70	9
10	Activity Assistants	6,556	6,556	63,776	9.73	10
11	Social Service Workers	6,430	7,854	104,346	13.29	11
12	Dietician	1,297	1,297	48,218	37.18	12
13	Food Service Supervisor	1,871	1,871	31,979	17.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,319	21,244	214,588	10.10	15
16	Dishwashers					16
17	Maintenance Workers	3,688	3,929	55,895	14.23	17
18	Housekeepers	15,945	17,223	172,709	10.03	18
19	Laundry	1,810	1,847	17,237	9.33	19
20	Administrator	1,844	1,844	98,684	53.52	20
21	Assistant Administrator					21
22	Other Administrative	1,829	1,829	39,352	21.52	22
23	Office Manager	1,842	1,842	47,687	25.89	23
24	Clerical	3,515	4,196	64,813	15.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,493	1,493	30,993	20.76	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,519	3,519	46,224	13.14	31
32	Other Health Care(specify)	6,599	6,599	129,363	19.60	32
33	Other(specify)	3,659	3,797	92,591	24.39	33
34	TOTAL (lines 1 - 33)	201,515	218,146	$ 3,233,417 *	$ 14.82	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	140	$ 6,843	3.1.3	35
36	Medical Director	132	12,000	3.9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	49	3,842	3.10.3	38
39	Pharmacist Consultant	154	2,740	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	79	5,316	3.12.3	45
46	Other(specify)				46
47	Assistant DON	302	25,456	3.10.3	47
48					48
49	TOTAL (lines 35 - 48)	856	$ 56,197		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Porter	Administrator		$ 98,684
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,684

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 374,595
TOTAL (agree to Schedule V, line 17, col. 3)	$ 374,595
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Inner View	Resident & Employee Surve	$ 1,066
Davis & Campbell	Attorney	60
Polsinelli, Shalton, Flanigan	Attorney	(311)
Cincinnati Insurance Co	Attorney	3,658
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,473

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,477
Unemployment Compensation Insurance	30,035
FICA Taxes	236,757
Employee Health Insurance	239,030
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	22,594
Pension Plan	5,500
Home Office Allocation	25,438
TOTAL (agree to Schedule V, line 22, col.8)	$ 638,831

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	41,394
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses	1,318
Dues	6,550
Subscriptions	1,093
Other	276
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,631

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,762
Seminar Expense	5,768
Home Office Allocation	12,415
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30,945

**See instructions.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Pleasant Meadows Christian Village **#** 0019166 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $5,598**

(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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,320** Line **3.10.2**

(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. $ **59,677**
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? **Yes**

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,155**

(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? **None**
d. Have vehicle usage logs been maintained? **No**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **LarsonAllen LLP**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.