FOR BHF USE							

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 Chr Village

Address: 400 W 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:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
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 7/1/12 to 6/30/13 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)	Susan McGhee
	(Title)	Chief Financial Officer
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Steve Howell Director
	(Firm Name & Address)	CliftonLarsonAllen LLP 6000 Washington Ave, Suite 1800, St. Louis, MO 63101
	(Telephone)	314-925-4497 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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	109	Skilled (SNF)	109	39,894	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	39,894	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,638	10,987	4,204	35,829	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,638	10,987	4,204	35,829	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.81%

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)
Meals, Lawn Care, and Maintenance for AL & IL residents

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 3,683

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	129,289	9,601	399,145	538,035		538,035		538,035			1
2	Food Purchase		111,903		111,903		111,903	(751)	111,152			2
3	Housekeeping	81,553	9,277		90,830		90,830		90,830			3
4	Laundry	22,855	9,144	8,683	40,682		40,682		40,682			4
5	Heat and Other Utilities			177,796	177,796		177,796	1,045	178,841			5
6	Maintenance	54,776	(2,156)	47,316	99,936		99,936	3,109	103,045			6
7	Other (specify):*											7
8	**TOTAL General Services**	288,473	137,769	632,940	1,059,182		1,059,182	3,403	1,062,585			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,199,378	132,900	12,508	2,344,786		2,344,786		2,344,786			10
10a	Therapy			601,349	601,349		601,349		601,349			10a
11	Activities	93,705	805		94,510		94,510	(1,683)	92,827			11
12	Social Services	176,375	341	4,140	180,856		180,856		180,856			12
13	CNA Training											13
14	Program Transportation			6,367	6,367		6,367		6,367			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,469,458	134,046	636,364	3,239,868		3,239,868	(1,683)	3,238,185			16
	C. General Administration											
17	Administrative	135,509	226	412,702	548,437		548,437	(343,854)	204,583			17
18	Directors Fees											18
19	Professional Services			31,353	31,353		31,353	25,466	56,819			19
20	Dues, Fees, Subscriptions & Promotions			15,984	15,984		15,984		15,984			20
21	Clerical & General Office Expenses	116,839	9,351	96,467	222,657		222,657	159,910	382,567			21
22	Employee Benefits & Payroll Taxes			645,716	645,716		645,716	30,388	676,104			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,781	4,781		4,781	12,513	17,294			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,574	87,574		87,574	6,602	94,176			26
27	Other (specify):* Marketing	51,014	307	13,224	64,545		64,545	(64,545)				27
28	**TOTAL General Administration**	303,362	9,884	1,307,801	1,621,047		1,621,047	(173,520)	1,447,527			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,061,293	281,699	2,577,105	5,920,097		5,920,097	(171,800)	5,748,297			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 Chr Village #0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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			241,150	241,150		241,150	24,280	265,430			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,506	8,506		8,506	1,245	9,751			32
33	Real Estate Taxes			149	149		149	(149)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,484	16,484		16,484		16,484			35
36	Other (specify):*											36
37	TOTAL Ownership			266,289	266,289		266,289	25,376	291,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			236,746	236,746		236,746	(9,832)	226,914			39
40	Barber and Beauty Shops	3	34,711		34,714		34,714		34,714			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			254,022	254,022		254,022		254,022			42
43	Other (specify):* Apt/Congregate			33,862	33,862		33,862	(33,862)				43
44	TOTAL Special Cost Centers	3	34,711	524,630	559,344		559,344	(43,694)	515,650			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,061,296	316,410	3,368,024	6,745,730		6,745,730	(190,118)	6,555,612			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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	(523)	2		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	(8,506)	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	(13,315)	21		24
25	Fund Raising, Advertising and Promotional	(64,545)	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	(35,922)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,811)		$	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)	(67,307)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (67,307)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (190,118)		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 Chr Village

ID# 0019166

Report Period Beginning: 7/1/12

Ending: 6/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (228)	2	1
2	Activity	(1,683)	11	2
3	Apartments/Congregate	(33,862)	43	3
4	Real Estate Taxes	(149)	33	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**	(35,922)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	(751)	0	0	0	0	0	0	0	0	0	0	(751)	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	1,045	0	0	0	0	0	0	0	0	0	1,045	5
6	Maintenance	0	3,109	0	0	0	0	0	0	0	0	0	3,109	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(751)	4,154	0	0	0	0	0	0	0	0	0	3,403	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	(1,683)	0	0	0	0	0	0	0	0	0	0	(1,683)	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**	(1,683)	0	0	0	0	0	0	0	0	0	0	(1,683)	16
	C. General Administration													
17	Administrative	0	(343,854)	0	0	0	0	0	0	0	0	0	(343,854)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,466	0	0	0	0	0	0	0	0	0	25,466	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(13,315)	173,225	0	0	0	0	0	0	0	0	0	159,910	21
22	Employee Benefits & Payroll Taxes	0	30,388	0	0	0	0	0	0	0	0	0	30,388	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,513	0	0	0	0	0	0	0	0	0	12,513	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	6,602	0	0	0	0	0	0	0	0	0	6,602	26
27	Other (specify):*	(64,545)	0	0	0	0	0	0	0	0	0	0	(64,545)	27
28	**TOTAL General Administration**	(77,860)	(95,660)	0	0	0	0	0	0	0	0	0	(173,520)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,294)	(91,506)	0	0	0	0	0	0	0	0	0	(171,800)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	24,280	0	0	0	0	0	0	0	0	0	24,280	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,506)	9,751	0	0	0	0	0	0	0	0	0	1,245	32
33	Real Estate Taxes	(149)	0	0	0	0	0	0	0	0	0	0	(149)	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	(8,655)	34,031	0	0	0	0	0	0	0	0	0	25,376	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	(9,832)	0	0	0	0	0	0	0	0	0	(9,832)	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):*	(33,862)	0	0	0	0	0	0	0	0	0	0	(33,862)	43
44	TOTAL Special Cost Centers	(33,862)	(9,832)	0	0	0	0	0	0	0	0	0	(43,694)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(122,811)	(67,307)	0	0	0	0	0	0	0	0	0	(190,118)	45

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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
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.	100.00%	$ 1,045	$ 1,045	1
2	V	6	Maintenance				3,109	3,109	2
3	V	17	Administrative	412,702			68,848	(343,854)	3
4	V	19	Progressional Services				25,466	25,466	4
5	V	21	Clerical				144,268	144,268	5
6	V	22	Employee Benefits				30,388	30,388	6
7	V	32	Interest				9,751	9,751	7
8	V	24	Travel and Seminars				12,513	12,513	8
9	V	26	Insurance				6,602	6,602	9
10	V	30	Depreciation				24,280	24,280	10
11	V	21	Non Patient Care Related				28,957	28,957	11
12	V	39	Pharmacy Cost	116,491	Senior Care Pharmacy		106,659	(9,832)	12
13	V								13
14	Total			$ 529,193			$ 461,886	$ * (67,307)	14

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

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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 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										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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority	X		Refinance Debt	$710.00	6/30/2007	$ 155,387	$ 146,205	5/15/1931	0.0567	$ 8,506	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$710.00		$ 155,387	$ 146,205			$ 8,506	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 155,387	$ 146,205			$ 8,506	15

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

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

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

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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 2012 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 2013 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:		
2008		8
2009		9
2010		10
2011		11
2012		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pleasant Meadows Chr 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 2012 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 2012.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	11-03-26-400-021	S26 T16 R12	$ 47.32	$
2.	11-03-26-300-014	S26 T16 R12	$ 101.26	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 148.58	$

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 X________ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,356 B. General Construction Type: Exterior Brick Frame Wood & Steel 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).

14 Unit Duplex/ Independent Living Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	46,356	1971	$ 15,876	1
2	Home Office Allocation			5,035	2
3	TOTALS	46,356		$ 20,911	3

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		1976	1976	$ 1,305,939	$ 31,866	40	$ 31,866	$	$ 1,181,715	4
5					228,890		20				5
6					1,235,805	41,194	30	41,194		556,112	6
7											7
8	Home Office Allocation				49,333	5,602		5,602		32,563	8
	Improvement Type**										
9	1978 Fixed Asset				18,615	-	Various	-		18,615	9
10	1979 Fixed Asset				3,855	84	Various	84		2,856	10
11	1980 Fixed Asset				533	12	Various	12		401	11
12	1981 Fixed Asset				597	-	Various	-		597	12
13	1986 Fixed Asset				8,955	-	Various	-		8,955	13
14	1988 Fixed Asset				5,975	-	Various	-		5,975	14
15	1990 Fixed Asset				12,080	-	Various	-		12,080	15
16	1991 Fixed Asset				13,548	-	Various	-		13,548	16
17	1992 Fixed Asset				600	-	Various	-		600	17
18	1993 Fixed Asset				3,891	100	Various	100		3,891	18
19	1995 Fixed Asset				1,222	-	Various	-		1,222	19
20	1996 Fixed Asset				35,958	220	Various	220		28,735	20
21	1997 Fixed Asset				4,910	-	Various	-		4,910	21
22	1998 Fixed Asset				4,072	-	Various	-		4,072	22
23	1999 Fixed Asset				29,456	475	Various	475		17,105	23
24	2000 Fixed Asset				23,248	-	Various	-		23,248	24
25	2001 Fixed Asset				19,480	128	Various	128		19,042	25
26	2002 Fixed Asset				27,274	1,257	Various	1,257		18,019	26
27	2003 Fixed Asset				48,786	3,701	Various	3,701		41,764	27
28	2004 Fixed Asset				9,301	719	Various	719		8,929	28
29	2005 Fixed Asset				28,724	2,133	Various	2,133		21,910	29
30	2006 Fixed Asset				19,467	604	Various	604		17,230	30
31	2007 Fixed Asset				59,079	6,247	Various	6,247		36,118	31
32	2008 Fixed Asset				52,405	5,328	Various	5,328		27,556	32
33	13 Handicapped stools w/lids			3/1/2009	2,445	244	10-000	244		1,059	33
34	Door Monitor Equipment			3/18/2009	5,887	589	10-000	589		2,551	34
35	Install 42x54 glass			5/1/2009	515	52	10-000	52		215	35
36	Install 49x61 glass			5/1/2009	615	62	10-000	62		256	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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	Kitchen door	9/25/2009	$ 599	$ 60	10-000	$ 60	$	$ 230	37
38	Install Double Pane Windows residents	10/13/2009	17,898	1,790	10-000	1,790		6,712	38
39	Duro-Last Membrane for Roof	10/13/2009	28,310	2,831	10-000	2,831		10,616	39
40	Mag Lock for Haven Center	4/21/2010	1,249	125	10-000	125		406	40
41	Electrical Circuits for Roof Top A/C	5/19/2010	5,995	600	10-000	600		1,898	41
42	Refurbishment	6/30/2010	253,764	25,376	10-000	25,376		78,244	42
43	Dining/Chapel HVAC &Ductwork	6/30/2010	188,788	18,879	10-000	18,879		58,210	43
44	CMS Survey Compliance	6/30/2010	30,924	3,092	10-000	3,092		9,535	44
45	Goodman R-22 2 Ton Condensing Unit	7/9/2010	726	73	10-000	73		218	45
46	Replace flooring in 4 bathrooms	8/31/2010	9,045	905	10-000	905		2,638	46
47	Rehab front hall - Wall Protector	9/30/2010	2,669	267	10-000	267		756	47
48	Carpeting	2/16/2011	1,722	172	10-000	172		416	48
49	300kva Transformer	2/17/2011	4,902	490	10-000	490		1,185	49
50	PTAC units	3/2/2011	2,004	200	10-000	200		468	50
51	Carpeting	3/17/2011	754	75	10-000	75		176	51
52	PTAC units	5/31/2011	2,456	246	10-000	246		532	52
53	R&R 15' Light Pole	6/15/2011	1,567	156	10-000	156		327	53
54	Parking Lot Repairs &Sealing Lot	6/27/2011	22,313	2,231	10-000	2,231		4,649	54
55	Dining &Angel hall - Flooring	6/30/2011	12,145	1,214	10-000	1,214		2,530	55
56	Fibro Self Contained Molding	7/18/2011	2,400	240	10-000	240		480	56
57	Replace Chapel Roof	8/10/2011	28,963	2,896	10-000	2,896		5,551	57
58	PTAC Digismart 12,000 BTU	8/15/2011	2,456	246	10-000	246		471	58
59	Shower/Tub	10/25/2011	1,000	100	10-000	100		175	59
60	Generator parts, contols for upgrade	12/9/2011	18,929	3,786	05-000	3,786		5,994	60
61	North Roof Shingles	5/31/2013	35,007	-	10-000	-		-	61
62	Electric Recepticle	5/31/2013	1,874	-	10-000	-		-	62
63	Reclass to equipment (See C04.13)		(19,413)	(1,294)		(1,294)		(10,137)	63
64	Less: Dissallowed Building & Land Imp		(98,902)						64
65	Retired Assets YTD Dep.			422		422			65
66	Plug to tie to G/L			40		40			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,821,603	$ 165,834		$ 165,834	$	$ 2,294,129	70

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

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	$ 468,580	$ 62,913	$ 62,913	$		$ 303,468	71
72	Current Year Purchases	20,121	1,175	1,175			1,175	72
73	Fully Depreciated Assets	564,059	9,394	9,394			564,059	73
74	Home Office Allocation	201,986	16,615	16,615			109,784	74
75	TOTALS	$ 1,254,746	$ 90,098	$ 90,098	$		$ 978,486	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 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	7,436	7,436		4	26,026	77
78										78
79	Home Office Allocation			18,157	2,062	2,062			7,305	79
80	TOTALS			$ 91,401	$ 9,498	$ 9,498	$		$ 76,831	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)	$ 5,188,661	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 265,430	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 265,430	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,349,446	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	$ 104,661	$ 4,086	$ 84,481	86
87	Congregate	422,572	10,343	307,661	87
88	Land	24,818			88
89	Disallowed Building & Land Imp.	98,902			89
90					90
91	TOTALS	$ 650,953	$ 14,429	$ 392,142	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 118,015	92
93			93
94			94
95		$ 118,015	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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 16,484 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 Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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.

   PMCV only hires certified C NA's

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.

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	$	3,907	$ 206,157	$	3,907	$ 206,157	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,705	98,116		1,705	98,116	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		9,414	297,076		9,414	297,076	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			$	15,026	$ 601,349	$	15,026	$ 601,349	14

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

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/13 (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	$ 2,412,587	$	1
2	Cash-Patient Deposits	35,501		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 79,822)	843,844		3
4	Supply Inventory (priced at)	49,254		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,773		6
7	Other Prepaid Expenses	10,932		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,360,891	$	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	4,277,284		14
15	Leasehold Improvements, at Historical Cost	131,025		15
16	Equipment, at Historical Cost	1,116,100		16
17	Accumulated Depreciation (book methods)	(3,591,935)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,210		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,975,378	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,336,269	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 189,140	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,501		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	308,095		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	61		32
33	Accrued Interest Payable	1,082		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Liabilities	199,083		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 732,962	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	146,205		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Auxiliary	12,826		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 159,031	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 891,993	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,444,276	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,336,269	$	48

*(See instructions.)

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,507,963	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,507,963	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(63,687)	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)**	$ (63,687)	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)**	$ 4,444,276	24 *

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

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,110,872	1
2	Discounts and Allowances for all Levels	(2,367,170)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,743,702	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,314,460	6
7	Oxygen	7,227	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,321,687	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	38,238	13
14	Non-Patient Meals	523	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	45	16
17	Sale of Drugs	257,039	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,298	19
20	Radiology and X-Ray	49,931	20
21	Other Medical Services	24,719	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 405,793	23
	D. Non-Operating Revenue		
24	Contributions	106,810	24
25	Interest and Other Investment Income***	43,064	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 149,874	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Congregate/Apartment Living	91,016	28
28a	Miscellaneous Revenue	(30,029)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 60,987	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,682,043	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,059,182	31
32	Health Care	3,239,868	32
33	General Administration	1,621,047	33
	B. Capital Expense		
34	Ownership	266,289	34
	C. Ancillary Expense		
35	Special Cost Centers	559,344	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,745,730	40
41	**Income before Income Taxes (line 30 minus line 40)****	(63,687)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (63,687)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,329,531	44
45	Private Pay - Net Inpatient Revenue	1,904,676	45
46	Medicare - Net Inpatient Revenue	(378,825)	46
47	Other-(specify)	(111,680)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,743,702	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.

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	2,064	2,319	$ 80,350	$ 34.65	1
2	Assistant Director of Nursing	1,560	1,696	56,181	33.13	2
3	Registered Nurses	16,678	18,203	444,943	24.44	3
4	Licensed Practical Nurses	22,566	24,917	508,064	20.39	4
5	CNAs & Orderlies	86,062	93,219	975,046	10.46	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,857	2,038	24,075	11.81	9
10	Activity Assistants	6,627	7,498	69,630	9.29	10
11	Social Service Workers	8,942	10,404	176,375	16.95	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	9,375	10,199	129,289	12.68	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,070	3,282	54,776	16.69	17
18	Housekeepers	5,914	6,388	81,553	12.77	18
19	Laundry	2,094	2,214	22,855	10.32	19
20	Administrator	1,921	2,225	147,823	66.43	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,832	2,160	58,439	27.06	23
24	Clerical	2,936	3,225	46,086	14.29	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,120	3,345	45,388	13.57	31
32	Other Health Care(specify)	2,603	2,699	89,407	33.13	32
33	Other(specify)	1,914	2,100	51,014	24.29	33
34	TOTAL (lines 1 - 33)	181,135	198,133	$ 3,061,293 *	$ 15.45	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	101	$ 4,760	3.1.3	35
36	Medical Director	132	12,000	3.9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	32	2,446	3.10.3	38
39	Pharmacist Consultant	174	3,530	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	61	4,140	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	501	$ 26,876		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Pleasant Meadows Chr Village | # 0019166 | Report Period Beginning: 7/1/12 | Ending: 6/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Vincent	Administrator		$ 135,509
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 135,509

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 412,702
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 412,702

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview	Survey	$ 1,445
Davis & Cambell	Legal	13,604
S.W Ross Land Surveying	Survey	2,400
Armstrong Tesdale	Legal	5,588
ECS Service Corp	Title Service	4,840
Polsinelli Shughart, PC	Legal	3,476
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 31,353

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 184,968
Unemployment Compensation Insurance	29,235
FICA Taxes	210,519
Employee Health Insurance	200,070
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	8,921
Executive Retention Expense	5,584
Employee Physicals	4,430
Employee Uniforms	989
457 Plan Expense	1,000
Home Office Allocation	30,388
TOTAL (agree to Schedule V, line 22, col.8)	$ 676,104

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 43)	1,003
Patient Background Checks 127	1,058
License	2,456
Dues	10,975
Subscriptions	304
Other	188
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,984

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,201
In-State Travel	1,616
Seminar Expense	964
Home Office Allocation	12,513
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,294

**See instructions.

Facility Name & ID Number Pleasant Meadows Chr Village # 0019166 Report Period Beginning: 7/1/12 Ending: 6/30/13

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 Chr Village** **# 0019166** **Report Period Beginning: 7/1/12** **Ending: 6/30/13**

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 $6,229**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,806** 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. $ **254,022**
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. $ **523**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
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: **CliftonLarsonAllen**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.