



Facility Name & ID Number Pleasant Meadows Christian Village

# 0019166 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

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 12/22/99

	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	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	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	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	Private Pay	4 Other		
8	SNF	<u>11,377</u>	<u>6,120</u>	<u>4,877</u>	<u>22,374</u>	8
9	SNF/PED					9
10	ICF	<u>4,445</u>	<u>2,910</u>		<u>7,355</u>	10
11	ICF/DD					11
12	SC	<u>2,784</u>	<u>4,433</u>		<u>7,217</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,606</u>	<u>13,463</u>	<u>4,877</u>	<u>36,946</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.86%

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

304 (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  NO

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

YES  NO

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

Date started 1974

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified 109 and days of care provided 4,877

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

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

STATE OF ILLINOIS

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	197,659	20,057	13,202	230,918		230,918		230,918		1
2	Food Purchase		207,764		207,764		207,764	(5,212)	202,552		2
3	Housekeeping	168,027	46,272		214,299		214,299		214,299		3
4	Laundry										4
5	Heat and Other Utilities			154,993	154,993		154,993	10,169	165,162		5
6	Maintenance	47,518	26,345	21,837	95,700		95,700	8,661	104,361		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>413,204</b>	<b>300,438</b>	<b>190,032</b>	<b>903,674</b>		<b>903,674</b>	<b>13,618</b>	<b>917,292</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,440	1,440		1,440		1,440		9
10	Nursing and Medical Records	1,806,314	278,308	4,229	2,088,851		2,088,851	(5,678)	2,083,173		10
10a	Therapy			257,116	257,116		257,116		257,116		10a
11	Activities	34,265			34,265		34,265	(20)	34,245		11
12	Social Services	89,063	2,289	3,486	94,838		94,838		94,838		12
13	CNA Training										13
14	Program Transportation			2,021	2,021		2,021	(120)	1,901		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,929,642</b>	<b>280,597</b>	<b>268,292</b>	<b>2,478,531</b>		<b>2,478,531</b>	<b>(5,818)</b>	<b>2,472,713</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	60,090	1,443	272,232	333,765		333,765	(215,285)	118,480		17
18	Directors Fees										18
19	Professional Services			38,461	38,461		38,461	9,754	48,215		19
20	Dues, Fees, Subscriptions & Promotions			43,631	43,631		43,631	(20,814)	22,817		20
21	Clerical & General Office Expenses	135,061	8,443	13,194	156,698		156,698	47,849	204,547		21
22	Employee Benefits & Payroll Taxes			486,077	486,077		486,077	27,733	513,810		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,203	18,203		18,203	5,699	23,902		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,806	93,806		93,806	846	94,652		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>195,151</b>	<b>9,886</b>	<b>965,604</b>	<b>1,170,641</b>		<b>1,170,641</b>	<b>(144,218)</b>	<b>1,026,423</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,537,997</b>	<b>590,921</b>	<b>1,423,928</b>	<b>4,552,846</b>		<b>4,552,846</b>	<b>(136,418)</b>	<b>4,416,428</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Pleasant Meadows Christian Village

#0019166

Report Period Beginning:

July 1, 2004

Ending:

June 30, 2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			160,581	160,581		160,581	30,637	191,218		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							334	334		32
33	Real Estate Taxes			115	115		115		115		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			160,696	160,696		160,696	30,971	191,667		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			24,857	24,857		24,857		24,857		39
40	Barber and Beauty Shops	18,134	1,472		19,606		19,606		19,606		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,678	59,678		59,678		59,678		42
43	Other (specify):*			35,871	35,871		35,871		35,871		43
44	<b>TOTAL Special Cost Centers</b>	18,134	1,472	120,406	140,012		140,012		140,012		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,556,131	592,393	1,705,030	4,853,554		4,853,554	(105,447)	4,748,107		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: July 1, 2004

Ending: June 30, 2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,308)	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	13,396	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(506)	21		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	(24,699)	21		24
25	Fund Raising, Advertising and Promotional	(4,156)	20		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 See Attached	(24,583)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (43,856)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(61,591)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (61,591)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (105,447)</b>		<b>37</b>

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

## Pleasant Meadows Christian Village

ID# 0019166

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending	\$ (1,904)	2	1
2	Activity	(20)	11	2
3	Marketing	(16,658)	20	3
4	Transportation	(120)	14	4
5	Related Pharmacy Profit	(5,678)	10	5
6	Miscellaneous	(203)	17	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(24,583)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166 Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,212)	0	0	0	0	0	0	0	0	0	0	(5,212)	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	10,169	0	0	0	0	0	0	0	0	0	10,169	5
6	Maintenance	0	8,661	0	0	0	0	0	0	0	0	0	8,661	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,212)</b>	<b>18,830</b>	<b>0</b>	<b>13,618</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,678)	0	0	0	0	0	0	0	0	0	0	(5,678)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	(120)	0	0	0	0	0	0	0	0	0	0	(120)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(5,818)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,818)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(203)	(215,082)	0	0	0	0	0	0	0	0	0	(215,285)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,754	0	0	0	0	0	0	0	0	0	9,754	19
20	Fees, Subscriptions & Promotions	(20,814)	0	0	0	0	0	0	0	0	0	0	(20,814)	20
21	Clerical & General Office Expenses	(25,205)	73,054	0	0	0	0	0	0	0	0	0	47,849	21
22	Employee Benefits & Payroll Taxes	0	27,733	0	0	0	0	0	0	0	0	0	27,733	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,699	0	0	0	0	0	0	0	0	0	5,699	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	846	0	0	0	0	0	0	0	0	0	846	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(46,222)</b>	<b>(97,996)</b>	<b>0</b>	<b>(144,218)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(57,252)</b>	<b>(79,166)</b>	<b>0</b>	<b>(136,418)</b>	<b>29</b>								



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 schedule.						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc	100.00%	\$ 10,169	\$ 10,169 1
2	V	6 Maintenance				8,661	8,661 2
3	V	17 Administrative	272,232			57,150	(215,082) 3
4	V	19 Professional Services				9,754	9,754 4
5	V	21 Clerical				73,054	73,054 5
6	V	22 Employee Benefits				27,733	27,733 6
7	V	24 Travel & Seminar				5,699	5,699 7
8	V	26 Insurance				846	846 8
9	V	30 Depreciation				17,241	17,241 9
10	V	32 Interest				334	334 10
11	V						
12	V						
13	V						
14	Total		\$ 272,232			\$ 210,641	\$ * (61,591) 14

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

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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: July 1, 2004 Ending: ne 30, 2005

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

1 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	<b>TOTALS</b>				\$	\$		\$	25

**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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2	<a href="#">This workpaper is not applicable.</a>																		
3												3							
4												4							
5												5							
	<b>Working Capital</b>																		
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9							
	<b>B. Non-Facility Related*</b>																		
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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 Christian Village**# **0019166** Report Period Beginning: **July 1, 2004** Ending: **June 30, 2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
			\$	<b>1</b>
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.)			\$	<b>n/a</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>#VALUE!</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>#VALUE!</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	_____	<b>8</b>	
	2001	_____	<b>9</b>	
	2002	_____	<b>10</b>	
	2003	_____	<b>11</b>	
	2004	_____	<b>12</b>	
<b>FOR OHF USE ONLY</b>				
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 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 Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-03-26-400-021</u>	<u>S26-T16-R12</u>	\$ <u>48.38</u>	\$ _____
2. <u>11-03-26-300-014</u>	<u>S26-T16-R12</u>	\$ <u>68.66</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>117.04</u>	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166 Report Period Beginning:

July 1, 2004 Ending:

June 30, 2005

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. 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	435,600	1971	\$ 15,876	1
2	Home Office Allocation			7,406	2
3	TOTALS	435,600		\$ 23,282	3

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	109	1975	1975	\$ 1,305,939	\$ 30,697	40	\$ 32,648	\$ 1,951	\$ 928,460
5				228,890		20	11,445	11,445	
6		2000	2000	1,235,805	41,194	30	41,194		226,567
7									
8	Home Office Allocation			53,607	1,728		1,728		26,931
	Improvement Type**								
9	Building Improvements		1979	3,855	84	46	84		2,226
10	Building Improvements		1980	533	12	44	12		300
11	Building Improvements Disposed		1982	20,257		20			20,257
12	Contractor A/C		1985	4,298		15			4,298
13	Sewer Repairs		1986	2,310	116	20	116		2,156
14	Condensing Unit A/C		1986	3,015		10			3,015
15	Building Improvements		1987	450		10			450
16	Building Improvements		1987	18,430		15			18,430
17	Building Improvements		1987	2,258		10			2,258
18	Building Improvements		1987	800	40	20	40		717
19	Building Improvements		1987	312		10			312
20	Building Improvements		1988	1,314		10			1,314
21	Building Improvements		1988	3,234		10			3,234
22	Building Improvements		1988	3,250		15			3,250
23	Building Improvements		1988	20,978		15			20,978
24	Phone Lines		1989	1,193		10			1,193
25	Wallcovering		1989	2,957		5			2,957
26	Wallcovering		1990	1,594		5			1,594
27	Reroof Portion of NH		1990	11,305	686	15	686		11,305
28	Rail/Baseboard		1990	775		10			775
29	Wallcovering		1990	1,835		5			1,835
30	Wallcovering		1991	1,835		5			1,835
31	Wallcovering		1991	5,136		5			5,136
32	Rail/Baseboard		1991	744	37	20	37		530
33	Wallcovering		1991	848		5			848
34	Remodeling			2,996	150	20	150		2,138
35	Roof		1991	8,000	533	15	533		7,373
36			1991	1,720	86	20	86		1,183

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Wallcovering	1991	\$ 3,854	\$	5	\$	\$	3,854	37
38	Sprinkler System	1991	602	40	15	40		543	38
39	Remodeling	1992	5,488	275	20	275		3,721	39
40	Remodeling	1992	6,610	331	20	331		4,430	40
41	Carpeting	1992	4,115		5			4,115	41
42	Carpeting	1992	8,647		5			8,647	42
43	Door	1992	551	37	15	37		481	43
44	Roof	1992	11,500	767	15	767		9,843	44
45	Carpeting	1992	806		5			806	45
46	Wallcovering	1992	3,384		5			3,384	46
47	Wallcovering	1993	3,081		5			3,081	47
48	Carpeting	1993	5,093		5			5,093	48
49	A/C System	1993	11,333	756	15	756		9,135	49
50	Sink	1993	2,199		10			2,199	50
51	Roof-NE/Gutters	1993	15,680	1,045	15	1,045		12,453	51
52	Gutters	1993	990	66	15	66		776	52
53	Baseboard/Wallcoverings	1993	9,755		5			9,755	53
54	10 Ton A/C Unit	1994	9,817	654	15	654		7,248	54
55	Roof Hall	1994	9,600	640	15	640		6,933	55
56	Roof Top	1994	15,088	1,006	15	1,006		10,898	56
57	Gutters	1994	934	27	10	27		934	57
58	Rooftop A/C	1994	44,062	2,937	15	2,937		31,328	58
59	Tile Bathrooms	1995	673		5			673	59
60	Kitchen Exhaust Fan	1995	1,680	143	10	143		1,680	60
61	Rooftop A/C	1995	7,197	597	10	597		7,197	61
62	Bathroom Motion Light	1995	7,299	607	10	607		7,299	62
63	Ceramic Tile shower	1995	7,546	688	10	688		7,546	63
64	Skylight Dining Room	1995	6,785	679	10	679		6,733	64
65	Fire Alarm	1995	1,222	122	10	122		1,190	65
66	Wallcoverings	1996	3,300		5			3,300	66
67	Fire Alarm	1996	17,700	1,770	10	1,770		16,373	67
68	Termite system	1996	11,000	220	20	220		3,062	68
69	Gutters	1996	6,258	626	10	626		5,425	69
70	TOTAL (lines 4 thru 69)		\$ 3,194,322	\$ 89,396		\$ 102,792	\$ 13,396	\$ 1,503,990	70

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

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>	\$ 3,194,322	\$ 89,396		\$ 102,792	\$ 13,396	\$ 1,503,990		1
2	Kick plates	1997 2,743	274	10	274		2,329		2
3	Wallcoverings	1997 3,290		5			3,290		3
4	Energy Management System	1997 15,018	1,502	10	1,502		12,266		4
5	Ventilation Fan	1997 2,167	217	10	217		1,718		5
6	Wallcoverings	1998 8,455		5			8,455		6
7	Rubber Roof Skylight	1998 3,100		5			3,100		7
8	Floor-Therapy room	1998 972		5			972		8
9	Fire Dampers	1999 7,952	795	10	795		5,035		9
10	Alarm System	2000 1,152	115	10	115		690		10
11	Quarry Tile	2000 2,033	66	5	66		2,033		11
12	Deck	2000 1,271	234	5	234		1,271		12
13	3 Ton A/C	2000 1,200	240	5	240		1,200		13
14	Deck	2000 719	143	5	143		719		14
15	Windows	2000 2,150	215	10	215		1,039		15
16	Wallcoverings	2000 2,792	558	5	558		2,558		16
17	Waterline and drain	7/5/2001 4,225	845	5	845		3,380		17
18	Smoke Detection Unit	11/29/2001 2,143	214	10	214		785		18
19	Rubber Roof (Northeast Section)	10/24/2001 7,737	774	10	774		2,903		19
20	Smoke Detector	12/13/2001 3,452	345	10	345		1,236		20
21	Windows	12/6/2001 1,923	128	15	128		459		21
22	Build/Install/Finish Fire Doors/Walls	1/14/2002 19,377	969	20	969		3,392		22
23	Install Window at Front Reception Desk	3/29/2002 967	64	15	64		213		23
24	Implementation of New Structured CAT5E Wiring	4/27/2002 1,790	90	20	90		293		24
25	Remove/Hang Wall paper-Beauty Shop Hallway	6/3/2002 1,124	112	10	112		345		25
26	65 Gallon AO Smith Water Heater	9/18/2002 3,900	390	10	390		1,105		26
27	(6) 11,800 btu A/C units w/wall sleeve	11/30/2002 4,016	402	10	402		1,072		27
28	Sanyo Condensing Unit & Evaporator	6/5/2003 1,100	110	10	110		229		28
29	Install High EFF Ballast Lights	6/27/2003 23,404	2,340	10	2,340		4,875		29
30	Copeland Compressor for Main A/C	8/20/2003 1,929	161	12	161		309		30
31	Hubbell Premise Data Cabinet	9/25/2003 8,689	579	15	579		1,062		31
32	Hubbell Premise Data Cabinet	9/15/2003 10,724	715	15	715		1,311		32
33	Vinyl Wallcoverings - Rooms 316 & 318	12/18/2003 2,940	588	5	588		931		33
34	TOTAL (lines 1 thru 33)	\$ 3,348,776	\$ 102,581		\$ 115,977	\$ 13,396	\$ 1,574,565		34

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

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,348,776	\$ 102,581		\$ 115,977	\$ 13,396	\$ 1,574,565		1
2	Walls in Oxygen Room to Roof Deck	2/16/2004 1,459	146	10	146		207		2
3	Install 24 Smoke Detectors	1/26/2004 5,730	573	10	573		860		3
4	Generator Governor	12/12/2003 507	101	5	101		160		4
5	1/2 Payment - Roof NW Wing	6/1/2004 9,400	940	10	940		940		5
6	Update Svsstem to Meet UL300 Fire Code	1/14/2005 1,908	954	1	954		954		6
7	Replace Heat Exchanger on Roof Top Unit	12/29/2004 2,112	246	5	246		246		7
8	Replace Large Window in Staff Dining Room	5/11/2005 2,160	36	10	36		36		8
9	Pella Awning	5/11/2005 959	16	10	16		16		9
10	Replace Compressor Kitchen A/C	6/17/2005 2,909	81	3	81		81		10
11	Cabling Project	6/9/2005 1,385	12	10	12		12		11
12	Entry Signs w/Directions	6/5/2005 2,825	24	10	24		24		12
13	Land Improvements	6/30/1978 18,615		20			18,615		13
14	Shrubs	4/30/1981 597		15			597		14
15	Asphalt Work	7/31/1984 10,350		15			10,350		15
16	Concrete & Dirt Work	8/31/1984 4,779	39	20	39		4,779		16
17	Landscaping	6/30/1986 6,549	327	20	327		6,240		17
18	Burning Bush	11/17/1986 96		10			96		18
19	Block Shute & Structure	10/6/1988 2,725	136	20	136		2,278		19
20	Resurface Parking Lot	6/30/1989 23,325		15			23,325		20
21	Landfill	6/30/1989 919		10			919		21
22	Landscaping	4/24/1991 2,721	136	20	136		1,938		22
23	Landscaping	6/30/1991 981	49	20	49		690		23
24	Water Meter	6/26/1991 500		10			500		24
25	Trees	6/25/1992 600	30	20	30		392		25
26	Landscaping	7/6/1993 2,000	100	20	100		1,200		26
27	Landscaping	8/29/1996 1,000		5			1,000		27
28	Resurface Parking Lot	9/26/1997 6,000		3			6,000		28
29	Gazebo	1/5/2000 6,274	627	10	627		3,762		29
30	Fencing	1/5/2000 3,610	361	10	361		2,166		30
31	Landscaping	11/8/1999 9,303	930	10	930		5,270		31
32	Fencing	1/5/2000 2,200	220	10	220		1,210		32
33	Flowers	5/22/2000 705	71	10	71		367		33
34	TOTAL (lines 1 thru 33)	\$ 3,483,979	\$ 108,736		\$ 122,132	\$ 13,396	\$ 1,669,795		34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 3,483,979	\$ 108,736		\$ 122,132	\$ 13,396	\$ 1,669,795		1
2	Flowers	5/16/2000 833	83	10	83		429		2
3	Seal Asphalt	7/28/2000 3,010	376	8	376		1,880		3
4	Landscaping	7/27/2000 3,564	356	10	356		1,780		4
5	Excavation of Dirt & Grass Seeding	10/17/2000 750	75	10	75		356		5
6	Break Up Old & Pour New Sidewalk	11/26/2001 665	67	10	67		302		6
7	Parking Lot Lighting	5/31/2005 1,988		10					7
8	Asphalt Additional Parking Lot Area	6/29/2005 6,395	36	10	36		36		8
9	E-Z Barn	5/20/1993 1,891	126	15	126		1,529		9
10	Garage	7/1/1999 19,001	475	40	475		2,850		10
11	Shed	4/3/2000 1,510	151	10	151		793		11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22	Less: Disposed	(20,257)					(20,257)		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,503,329	\$ 110,481		\$ 123,877	\$ 13,396	\$ 1,659,493		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 445,543	\$ 48,040	\$ 48,040	\$	Various	\$ 253,319	71
72	Current Year Purchases	30,346	3,788	3,788		Various	3,788	72
73	Fully Depreciated Assets	310,930				Various	310,930	73
74	Home Office Allocation	94,881	13,104	13,104			50,549	74
75	TOTALS	\$ 881,700	\$ 64,932	\$ 64,932	\$		\$ 618,586	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	1994	\$ 43,500	\$	\$	\$	8	\$ 43,500	76
77										77
78										78
79	Home Office Allocation			11,140	2,409	2,409			4,238	79
80	TOTALS			\$ 54,640	\$ 2,409	\$ 2,409	\$		\$ 47,738	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 12L, if applicable)	\$ 4,462,951	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 177,822	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 191,218	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$ 13,396	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 2,325,817	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	Apartment	\$ 95,951	\$ 2,426	\$ 74,288	86
87	Independent Living	446,267	10,711	250,197	87
88	Land	24,818			88
89					89
90					90
91	TOTALS	\$ 567,036	\$ 13,137	\$ 324,485	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: This workpaper is not applicable.  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

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

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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

Page 17

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2005 (last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 128,109	1
2	Cash-Patient Deposits	8,634	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 105,136 )	917,874	3
4	Supply Inventory (priced at FIFO )	18,299	4
5	Short-Term Investments	718,914	5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	7,163	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>Accrued Int Rec</u>	15,186	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,814,179	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	40,694	13
14	Buildings, at Historical Cost	3,870,337	14
15	Leasehold Improvements, at Historical Cost	121,054	15
16	Equipment, at Historical Cost	830,867	16
17	Accumulated Depreciation (book methods)	(2,568,584)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds	1,458,617	21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,752,985	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,567,164	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 124,733	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	8,634	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	239,727	30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	176	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36			36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 373,270	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 373,270	46
47	<b>TOTAL EQUITY (page 18, line 24)</b>	\$ 5,193,894	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,567,164	48

\*(See instructions.)

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,149,789	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,149,789	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	594,109	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 594,109</b>	17
<b>B. Transfers (Itemize):</b>			
18	Transfer out to affiliates	(550,004)	18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ (550,004)</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 5,193,894</b>	24 *

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

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,408,864	1
2	Discounts and Allowances for all Levels	(877,823)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,531,041</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	499,376	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 499,376</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	26,300	13
14	Non-Patient Meals	3,308	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,356	19
20	Radiology and X-Ray	15,961	20
21	Other Medical Services	3,828	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 66,753</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	91,646	24
25	Interest and Other Investment Income***	100,959	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 192,605</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Unrealized G (L) on Sale of Equity	16,502	28
28a	Residential/Congregate	141,386	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 157,888</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,447,663</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	903,674	31
32	Health Care	2,478,531	32
33	General Administration	1,170,641	33
<b>B. Capital Expense</b>			
34	Ownership	160,696	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	80,334	35
36	Provider Participation Fee	59,678	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,853,554</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>594,109</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 594,109</b>	<b>43</b>

\* 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 &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning: July 1, 2004

Ending:

June 30, 2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,877	2,077	\$ 52,007	\$ 25.04	1
2	Assistant Director of Nursing	1,859	2,045	40,692	19.90	2
3	Registered Nurses	9,127	10,073	235,956	23.42	3
4	Licensed Practical Nurses	28,926	29,806	530,964	17.81	4
5	CNAs & Orderlies	83,666	89,935	913,984	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,676	2,870	32,711	11.40	8
9	Activity Director	1,729	1,779	21,398	12.03	9
10	Activity Assistants	1,190	1,226	12,867	10.50	10
11	Social Service Workers	9,023	9,298	89,063	9.58	11
12	Dietician					12
13	Food Service Supervisor	1,355	1,434	21,821	15.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,083	18,723	175,838	9.39	15
16	Dishwashers					16
17	Maintenance Workers	1,856	2,707	47,518	17.55	17
18	Housekeepers	17,019	17,640	168,027	9.53	18
19	Laundry					19
20	Administrator	2,109	2,160	60,090	27.82	20
21	Assistant Administrator					21
22	Other Administrative	1,871	1,918	52,969	27.62	22
23	Office Manager	1,888	1,935	47,002	24.29	23
24	Clerical	2,796	2,862	35,090	12.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,862	1,862	18,134	9.74	33
34	TOTAL (lines 1 - 33)	188,912	200,350	\$ 2,556,131 *	\$ 12.76	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	292	\$ 13,202	1.3	35
36	Medical Director	144	1,440	9.3	36
37	Medical Records Consultant	8	263	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,283	10.3	39
40	Physical Therapy Consultant	2,243	147,575	10A.3	40
41	Occupational Therapy Consultant	1,430	91,324	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	231	18,217	10A.3	43
44	Activity Consultant			11.3	44
45	Social Service Consultant	53	3,486	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,593	\$ 278,790		49

## C. CONTRACT NURSES

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





Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning: July 1, 2004

Ending: June 30, 2004

## 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. Life Services Network - \$5,318
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,269 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. n/a
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES        NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,678  
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. \$ 3,308
- (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. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. It will be provided upon completion.
- (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 \$2500, 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.

Pleasant Meadows Christian Village  
Allocation on Benefits

6/30/2005

kdb  
10/21/2004

<u>Payroll Tax</u>	<u>Unemploy Contrib</u>	<u>Worker's Comp</u>	<u>Health Ins</u>	<u>W C Med Expense</u>	<u>Employee Uniforms</u>	<u>Employee Expense</u>	<u>Employee Physicals</u>	
13,081.96	3,091.50	81,599.00	14,760.00		-0.01	14,478.63		127,011.08
261.92			4,920.00	538.65			1,242.00	6,962.57
3,176.97			4,920.00			205.43		8,302.40
14,899.37			9,840.00					24,739.37
11,794.68			17,500.00					29,294.68
133,232.78			131,380.00					264,612.78
9,255.57			9,840.00					19,095.57
1,138.97			4,920.00					6,058.97
<b>186,842.22</b>	<b>3,091.50</b>	<b>81,599.00</b>	<b>198,080.00</b>	<b>538.65</b>	<b>-0.01</b>	<b>14,684.06</b>	<b>1,242.00</b>	<b>486,077.42</b>

Line 3.22.3