

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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:** 0021014

**Facility Name:** PLEASANT HILL VILLAGE

**Address:** 1010 WEST NORTH STREET GIRARD 62640  
 Number City Zip Code

**County:** MACOUPIN

**Telephone Number:** (217) 627-2181 **Fax #** (217) 627-3604

**HFS ID Number:** 37-0330985001

**Date of Initial License for Current Owners:** 3/01/76

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501 (c) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

**In the event there are further questions about this report, please contact:**  
**Name:** PAULETTE BUCH-MILLER **Telephone Number:** (217) 627-9502

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/06 to 6/30/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>PAULETTE BUCH-MILLER</u>	
	(Title) <u>ADMINISTRATOR</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>SEE ATTACHED COMPILATION REPORT</u>	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

**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 HILL VILLAGE

# 0021014 Report Period Beginning: 7/1/06 Ending: 6/30/07

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	17,785	11,374		29,159
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	17,785	11,374		29,159

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.52%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 3/01/76

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

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

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/1/06 Ending: 6/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	162,296	9,915	4,128	176,339		176,339		176,339		1
2	Food Purchase		141,025		141,025		141,025	(608)	140,417		2
3	Housekeeping	55,681	7,480		63,161		63,161		63,161		3
4	Laundry	51,740	9,511	2,648	63,899		63,899		63,899		4
5	Heat and Other Utilities			101,956	101,956	(826)	101,130		101,130		5
6	Maintenance	48,583	2,334	11,266	62,183		62,183	(8,166)	54,017		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>318,300</b>	<b>170,265</b>	<b>119,998</b>	<b>608,563</b>	<b>(826)</b>	<b>607,737</b>	<b>(8,774)</b>	<b>598,963</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,010,546	31,932	217,484	1,259,962		1,259,962		1,259,962		10
10a	Therapy			1,125	1,125		1,125		1,125		10a
11	Activities	53,901	1,741	3,411	59,053		59,053		59,053		11
12	Social Services	18,168	1,645		19,813		19,813		19,813		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>CHAPLAIN</b>	24,238			24,238		24,238		24,238		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,106,853</b>	<b>35,318</b>	<b>228,020</b>	<b>1,370,191</b>		<b>1,370,191</b>		<b>1,370,191</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	106,462			106,462		106,462	(13,050)	93,412		17
18	Directors Fees										18
19	Professional Services			63,724	63,724		63,724		63,724		19
20	Dues, Fees, Subscriptions & Promotions			20,579	20,579		20,579	(10,962)	9,617		20
21	Clerical & General Office Expenses	25,298	7,972	13,523	46,793		46,793	(4,885)	41,908		21
22	Employee Benefits & Payroll Taxes			221,383	221,383		221,383		221,383		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,390	2,390		2,390		2,390		24
25	Other Admin. Staff Transportation			1,331	1,331		1,331		1,331		25
26	Insurance-Prop.Liab.Malpractice			108,473	108,473		108,473		108,473		26
27	Other (specify):* <b>RISK MANAGER</b>	27,294			27,294		27,294		27,294		27
28	<b>TOTAL General Administration</b>	<b>159,054</b>	<b>7,972</b>	<b>431,403</b>	<b>598,429</b>		<b>598,429</b>	<b>(28,897)</b>	<b>569,532</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,584,207</b>	<b>213,555</b>	<b>779,421</b>	<b>2,577,183</b>	<b>(826)</b>	<b>2,576,357</b>	<b>(37,671)</b>	<b>2,538,686</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 & ID Number PLEASANT HILL VILLAGE

#0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			101,179	101,179		101,179		101,179			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,917	42,917		42,917	(4,763)	38,154			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,228	5,228		5,228		5,228			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			149,324	149,324		149,324	(4,763)	144,561			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					826	826		826			40
41	Coffee and Gift Shops			9,933	9,933		9,933		9,933			41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* <b>FINES &amp; PENALTIES</b>			47,150	47,150		47,150	(47,150)				43
44	<b>TOTAL Special Cost Centers</b>			110,738	110,738	826	111,564	(47,150)	64,414			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,584,207	213,555	1,039,483	2,837,245		2,837,245	(89,584)	2,747,661			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 HILL VILLAGE

# 0021014

Report Period Beginning: 7/1/06

Ending: 6/30/07

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(608)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,685)	21		5
6	Rented Facility Space	(1,200)	21		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	(4,763)	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	(47,150)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,157)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,805)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (68,368)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (68,368)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		826	5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 826		47

BHF USE ONLY						
48		49		50		51
						52

PLEASANT HILL VILLAGE

ID# 0021014

Report Period Beginning: 7/1/06

Ending: 6/30/07

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

## 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	(608)	0	0	0	0	0	0	0	0	0	0	(608)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(8,166)	0	0	0	0	0	0	0	0	0	(8,166)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(608)</b>	<b>(8,166)</b>	<b>0</b>	<b>(8,774)</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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(13,050)	0	0	0	0	0	0	0	0	0	(13,050)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,962)	0	0	0	0	0	0	0	0	0	0	(10,962)	20
21	Clerical & General Office Expenses	(4,885)	0	0	0	0	0	0	0	0	0	0	(4,885)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(15,847)</b>	<b>(13,050)</b>	<b>0</b>	<b>(28,897)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(16,455)</b>	<b>(21,216)</b>	<b>0</b>	<b>(37,671)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY		
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS		
		(to Sch V, col.7)													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,763)	0	0	0	0	0	0	0	0	0	0	0	(4,763)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	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	0	36
37	<b>TOTAL Ownership</b>	<b>(4,763)</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>0</b>	<b>(4,763)</b>	<b>37</b>
	<b>Ancillary Expense</b>														
	<b>E. Special Cost Centers</b>														
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	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	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(47,150)	0	0	0	0	0	0	0	0	0	0	0	(47,150)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(47,150)</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>0</b>	<b>(47,150)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(68,368)</b>	<b>(21,216)</b>	<b>0</b>	<b>(89,584)</b>	<b>45</b>									

Facility Name & ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning: 7/1/06

Ending: 6/30/07

**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
N/A	N/A	N/A		PLEASANT HILL RESIDENCE	GIRARD	INDEPENDENT LIVING CENTER

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 ADMINISTRATIVE WAGES	\$ 13,050	PLEASANT HILL RESIDENCE		\$	\$ (13,050)	1
2	V	6 MAINTENANCE WAGES	8,166	PLEASANT HILL RESIDENCE			(8,166)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 21,216			\$	\$ * (21,216)	14

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

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/1/06 Ending: 6/30/07

## 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	N/A								\$	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 HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HICKORY POINT BANK		X	REFINANCE FACILITY CON	\$3,353.00	10/21/03	\$ 591,489	\$ NONE	10/15/06	0.0325	\$ 5,740	1								
2	HICKORY POINT BANK		X	REFINANCE FACILITY CON	\$3,982.00	10/15/06	525,081	512,451	10/15/11	0.0555	19,757	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	FIRST NATIONAL BANK		X	OPERATING LINE OF CRED	INTEREST	1/31/06	300,050	NONE	12/31/06	0.0775	8,998	6								
7	FIRST NATIONAL BANK		X	OPERATING LINE OF CRED	INTEREST	12/28/06	400,050	249,490	12/15/07	0.0850	8,178	7								
8	VARIOUS VENDORS		X								244	8								
9	<b>TOTAL Facility Related</b>				<b>\$7,335.00</b>		<b>\$ 1,816,670</b>	<b>\$ 761,941</b>			<b>\$ 42,917</b>	<b>9</b>								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 1,816,670</b>	<b>\$ 761,941</b>			<b>\$ 42,917</b>	<b>15</b>								

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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PLEASANT HILL VILLAGE COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0021014

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 HILL VILLAGE

# 0021014 Report Period Beginning:

7/1/06 Ending:

6/30/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,000 B. General Construction Type: Exterior BRICK Frame STEEL & FIRE RESISTANT Number of Stories 1

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

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

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

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

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

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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: 29,505 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: 1973-1976

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY GROUNDS</u>	<u>243,065</u>	<u>1905 - 1975*</u>	<u>\$ 28,500</u>	1
2					2
3	<b>TOTALS</b>	<b>243,065</b>		<b>\$ 28,500</b>	<b>3</b>

Facility Name &amp; ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1976	1976	\$ 975,998	\$ 24,400	40	\$ 24,400	\$	\$ 764,532	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		LANDSCAPING, PA SYSTEM PHV SIGN DIRECTORY BOARD		1976	5,916						9
10		DIRECTORY BOARD LETTERS, PATIO CEMENT, LANDSCAPING		1977	1,273						10
11		LANDSCAPING, AIR CONDITIONER, FLAG PLE LIGHT		1978	6,194						11
12		LANDSCAPING, FENCE, CABINETS, INTERCOM, & MIKE MIXER		1980	3,688						12
13		REMODELING		1981	485						13
14		ENERGY CONTROL SYSTEM, REMODELING		1982	19,060						14
15		CABINETS		1983	271						15
16		CABINET TOP		1984	408						16
17		GARAGE SHOP, STORAGE BLDG, REMODELING, DRIVEWAY		1985	74,072						17
18		REMODELING		1986	5,469						18
19		BACKFLOW PREVENTOR, WINDOW, & MIXING VALVE		1989	8,180						19
20		FIRE ALARM		1991	1,298						20
21		NEW ROOF, STORM WINDOWS, PAVILION		1992	61,405	36,213		36,213		503,385	21
22		LANDSCAPING		1993	1,240						22
23		LANDSCAPING, ROOF		1994	43,344						23
24		NEW ROOF, REMODELING, AIR CONDITIONERS		1994	32,226						24
25		SECURITY SYSTEM, REMODELING		1994	6,907						25
26		ARCHITECH, REMODELING, A/C, CARPET, FLOOR, PAINT & PAPER		1995	40,250						26
27		DRIVEWAY, ARCHITECH, LANDSCAPING, A/C WINDOW TREATMENT		1995	28,013						27
28		ROOF, WATERLINE, COVEBASE, & HAND RAIL		1996	40,657						28
29		LANDSCAPING		1997	915						29
30		ROOF TOP AIR CONDITIONER		1997	6,795						30
31		PAINT & WALL PAPER		1997	24,720						31
32		FLOORING		1997	12,182						32
33		COVEBASE		1997	2,713						33
34		REPLACE CEILING		1997	16,220						34
35		EXHAUST FAN		1997	428						35
36		WATER HYDRANT		1997	527						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 &amp; ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

**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	PARKING AREA	1998	\$ 17,920	\$		\$	\$	\$	37
38	LANDSCAPING	1998	715						38
39	ARCHITECH FEES	1998	8,912						39
40	PAINT & WALL PAPER	1998	4,691						40
41	FLOORING	1998	428						41
42	WALL TREATMENTS & PICTURES	1998	442						42
43	WINDOWS	1998	2,123						43
44	OUTDOOR LIGHTING	1998	2,761						44
45	FIRE ALARM SYSTEM	1998	3,218						45
46	HEATING & COOLING SYSTEM	1998	1,824						46
47	LANDSCAPING	1999	1,439						47
48	DEMENTIA WING	1999	287,249						48
49	DEMENTIA WING ELECTRICAL	1999	589						49
50	DEMENTIA WING SURVEY	1999	3,250						50
51	PAINT & WALL PAPER	1999	4,025						51
52	WINDOW TREATMENT	1999	526						52
53	CARPET	1999	2,531						53
54	HEATING & COOLING SYSTEM	1999	4,384						54
55	ROOF TOP AIR CONDITIONER	1999	6,940						55
56	LANDSCAPING	2000	1,600						56
57	DEMENTIA WING	2000	19,566						57
58	SURVEY INDEPENDENT LIVING CENTER	2000	1,875						58
59	SECURITY DOOR ALARM	2000	1,415						59
60	HOT WATER HEATING SYSTEM	2000	26,436						60
61	CARPET	2000	4,462						61
62	VINAL SLIDING DOOR	2000	2,359						62
63	HEATING & COOLING SYSTEM	2000	6,368						63
64	LANDSCAPING	2001	1,600						64
65	ELECTRICAL WORK	2001	850						65
66	MASTER PLAN	2001	10,000						66
67	NEW LAUNDRY ROOM WALL	2001	497						67
68	DUCT WORK	2001	344						68
69	WATER LINE	2001	60,000						69
70	TOTAL (lines 4 thru 69)		\$ 1,912,193	\$ 60,613		\$ 60,613	\$	\$ 1,267,917	70

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

Facility Name &amp; ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

**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>		\$ 1,912,193	\$ 60,613		\$ 60,613	\$	\$ 1,267,917	1
2	SLIDER WINDOWS	2001	2,469						2
3	FLOORING	2001	2,364						3
4	PAINT	2001	475						4
5	FIRE ALARM SYSTEM	2001	3,317						5
6	INTERIOR DECORATING	2001	1,863						6
7	ELECTRIC HEAT UNITS	2001	7,940						7
8	DRIVEWAY	2002	21,209						8
9	SIDEWALK	2002	960						9
10	DOORS	2002	2,515						10
11	AC CONDENSER	2002	1,572						11
12	WINDOWS	2002	266						12
13	EXHAUST FAN	2002	1,802						13
14	COUNTER TOP & WALL REPAIR	2002	604						14
15	ELECTRICAL GROUNDING	2002	2,581						15
16	POLE LIGHT	2002	3,337						16
17	ELECTRIC HEAT	2002	704						17
18	ENTRYWAY CULVERT	2003	2,600						18
19	700' 6" TILE	2003	1,561						19
20	CONCRETE WASHER BASE	2003	750						20
21	PERGOLA	2003	2,800						21
22	MASTER PLAN DEVELOPMENT	2003	892						22
23	HEATER	2003	1,064						23
24	SIGN LIGHTING	2003	2,529						24
25	CARPET	2003	378						25
26	LANDSCAPING	2004	4,748						26
27	ELECTRICAL WORK	2004	1,025						27
28	SECURITY DOOR ALARM	2004	812						28
29	GENERATOR & TRANSFER SWITHC	2004	9,151						29
30	LAUNDRY ROOM A.C.	2004	11,320						30
31	RETAINING WALL GAZEBO AREA	2005	7,254						31
32	ALUMINUM DOORS	2005	2,700						32
33	GAZEBO	2005	7,778						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,023,533	\$ 60,613		\$ 60,613	\$	\$ 1,267,917	34

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

Facility Name & ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning:

7/1/06

Ending:

6/30/07

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		\$ 2,023,533	\$ 60,613		\$ 60,613	\$	\$ 1,267,917	1
2	WINDOW TREATMENT	2005	868						2
3	HEAT & COOL SYSTEM	2005	566						3
4	FIRE SAFETY SYSTEM	2005	1,041						4
5	SIDEWALK	2006	5,230						5
6	GAZEBO	2005	3,139						6
7	PAVILLION	2006	576						7
8	OUTSIDE EMERGENCY LIGHTING	2005	1,081						8
9	NEW SOFFIT, FASCIA, GUTTERING	2007	1,352						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	TOTAL (lines 1 thru 33)		\$ 2,037,386	\$ 60,613		\$ 60,613	\$	\$ 1,267,917	34

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

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	\$ 269,144	\$ 27,728	\$ 27,728	\$	VARIOUS	\$ 201,892	71
72	Current Year Purchases	15,864	920	920		VARIOUS	920	72
73	Fully Depreciated Assets	324,555				VARIOUS	324,555	73
74								74
75	TOTALS	\$ 609,563	\$ 28,648	\$ 28,648	\$		\$ 527,367	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	HOME UPKEEP	PICKUP W/BLADE	2003	\$ 2,001	\$ 400	\$ 400	\$	5	\$ 1,733	76
77	RESIDENT OUTINGS	BUS	2003	57,588	11,518	11,518		5	48,951	77
78										78
79										79
80	TOTALS			\$ 59,589	\$ 11,918	\$ 11,918	\$		\$ 50,684	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,735,038	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,179	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,179	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)	\$ 1,845,968	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number PLEASANT HILL VILLAGE

# 0021014

Report Period Beginning: 7/1/06

Ending: 6/30/07

**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:				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 5,228      Description: OFFICE COPIER

(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.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/1/06 Ending: 6/30/07

**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><u>AIDES WERE ALREADY TRAINED</u></p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist		hrs	\$				\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		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	<b>TOTAL</b>			\$				\$		\$				\$		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 HILL VILLAGE# 0021014Report Period Beginning: 7/1/06

Ending:

6/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/07

(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	\$ 122,195	\$	1
2	Cash-Patient Deposits	2,581		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,142 )	255,009		3
4	Supply Inventory (priced at COST )	9,172		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,004		6
7	Other Prepaid Expenses	498		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 414,459	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	28,500		13
14	Buildings, at Historical Cost	1,938,043		14
15	Leasehold Improvements, at Historical Cost	99,848		15
16	Equipment, at Historical Cost	676,001		16
17	Accumulated Depreciation (book methods)	(1,845,968)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,505		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,763)		20
21	Restricted Funds	34,916		21
22	Other Long-Term Assets (spe CAPITAL CONTRIB	68,430		22
23	Other(specify): FARM LAND	60,000		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,075,512	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,489,971	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 100,190	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,581		28
29	Short-Term Notes Payable	249,490		29
30	Accrued Salaries Payable	59,265		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,729		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,994		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>	\$ 419,249	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	512,451		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>	\$ 512,451	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 931,700	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 558,271	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,489,971	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>691,036</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>691,036</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(132,765)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (132,765)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>558,271</b>	<b>24</b> *

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

Facility Name & ID Number PLEASANT HILL VILLAGE# 0021014Report Period Beginning: 7/1/06Ending: 6/30/07**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	\$ 2,624,580	1
2	Discounts and Allowances for all Levels	(3,650)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,620,930</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</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	10,447	12
13	Barber and Beauty Care	826	13
14	Non-Patient Meals	608	14
15	Telephone, Television and Radio	3,685	15
16	Rental of Facility Space	1,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 16,766</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	22,127	24
25	Interest and Other Investment Income***	4,763	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 26,890</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PHR REIMB 21,216; ENDOWMENT FUND 2,150</b>	<b>23,366</b>	28
28a	<b>FARM INCOME 1,515; FUND RAISING 15,013</b>	<b>16,528</b>	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 39,894</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,704,480</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	608,563	31
32	Health Care	1,370,191	32
33	General Administration	598,429	33
<b>B. Capital Expense</b>			
34	Ownership	149,324	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	9,933	35
36	Provider Participation Fee	53,655	36
<b>D. Other Expenses (specify):</b>			
37	<b>FINES &amp; PENALTIES</b>	<b>47,150</b>	<b>37</b>
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,837,245</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(132,765)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (132,765)</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 & ID Number **PLEASANT HILL VILLAGE**

# **0021014**

Report Period Beginning:

7/1/06

Ending:

6/30/07

**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	1,629	1,757	\$ 56,269	\$ 32.03	1
2	Assistant Director of Nursing	2,256	2,354	44,624	18.96	2
3	Registered Nurses	2,937	3,383	56,745	16.77	3
4	Licensed Practical Nurses	14,809	15,950	269,002	16.87	4
5	CNAs & Orderlies	58,833	62,008	583,906	9.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,031	2,126	18,985	8.93	9
10	Activity Assistants	4,947	5,024	34,916	6.95	10
11	Social Service Workers	1,904	2,043	18,168	8.89	11
12	Dietician					12
13	Food Service Supervisor	2,362	2,615	24,114	9.22	13
14	Head Cook	3,302	3,561	28,480	8.00	14
15	Cook Helpers/Assistants	9,682	10,581	82,274	7.78	15
16	Dishwashers	3,724	3,798	27,428	7.22	16
17	Maintenance Workers	3,507	3,851	48,583	12.62	17
18	Housekeepers	6,883	7,348	55,681	7.58	18
19	Laundry	6,072	6,450	51,740	8.02	19
20	Administrator	3,448	3,870	106,462	27.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,957	2,134	25,298	11.85	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 C: CHAPLAIN	1,522	1,730	24,238	14.01	32
33	Other(specify) RISK MANAGER	1,124	1,392	27,294	19.61	33
34	TOTAL (lines 1 - 33)	132,929	141,975	\$ 1,584,207 *	\$ 11.16	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	129	\$ 4,128	L1,C3	35
36	Medical Director	48	6,000	L9,C3	36
37	Medical Records Consultant	44	1,132	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	L10,C3	39
40	Physical Therapy Consultant	23	1,125	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	59	3,411	L11,C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	327	\$ 16,996		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	17	\$ 870	L10,C3	50
51	Licensed Practical Nurses	669	21,989	L10,C3	51
52	Certified Nurse Assistants/Aides	9,992	185,155	L10,C3	52
53	TOTAL (lines 50 - 52)	10,678	\$ 208,014		53





**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. ASSN BRETHERN CAREGIVERS 1,950; LSN 3,699
- (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? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655  
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? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? N/A  
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: GREGORY M. BIERMAN, CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

**SCHEDULE XI. OWNERSHIP COSTS: PAGE 11**

FACILITY GROUNDS COSIST OF 5.58 ACRES  
ORIGINALLY THE LAND WAS SECURED BY DONATION IN 1905 BUT DESIGNATED AS HOME SITE IN 1975  
AT WHICH TIME IT WAS APPRAISED AT A VALUATION OF \$28,500

**SCHEDULE XI OWNERSHIP COSTS: PAGE 12, 12A, 12B, 12C**

IMPROVEMENTS:  
SYSTEM DOES NOT DISTINGUISH BY YEAR, ONLY BY ASSET CLASSIFICATION.

## STATE OF ILLINOIS

Page 25

Facility Name & ID Number BRETHERN HOME OF GIRARD DBA PLEASANT HILL VILLAGE # 21014 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

<u>NAME</u>	<u>DATE</u>	<u>LOCATION</u>	<u>TITLE</u>	<u>SPONSOR</u>	<u>REGISTRATION</u>	<u>MEALS</u>	<u>LODGING</u>	<u>TRAVEL</u>	<u>MILEAGE</u>	
Lenore Holmes	7/10/2006	Champaign	Risk Manager	Life Service Network					130	
Paulette Miller	8/31/2006	Decatur	Administrator	Life Service Network					63	
Diana Schmidt	9/8/2006	Springfield	Activities Director	Outcome Services	65					
Diana Schmidt	9/13/2006	Springfield	Activities Director	Outcome Services	400					
Lenore Holmes	10/17/2006	Chicago	Risk Manager	PCRRG		79	459	23	13	
Linda Sanders	1/18/2007	Carlisle	Social Services Dir	Outcome Services	153					
Becky Pierson	1/23/2007	PHV	Dietary Supervisor	Univ of Flordia	562					
Paulette Miller	1/25/2007	Springfield	Administrator	Life Service Network	99					
Monica Lederbrand & Mary Baker	2/8/2007	Springfield	Administrator DON	Life Service Network	115					
Various employees	2/10/2007	PHV - Audio Seminar	Various	AAHSA	79					
Mary Baker	4/1/2007	Decatur	DON	Alzheimer's Association	75					
Carmin Wolfe	4/1/2007	Decatur	RN	Alzheimer's Association	75					
					1623	79	459	23	206	2390