

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	35,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	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	16,702	10,376		27,078
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	16,702	10,376		27,078

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.49%

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: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number PLEASANT HILL HEALTHCARE # 0021014 Report Period Beginning: 07/01/07 Ending: 06/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	167,811	12,386	4,224	184,421		184,421		184,421		1
2	Food Purchase		136,159		136,159		136,159	(402)	135,757		2
3	Housekeeping	55,703	9,016		64,719		64,719		64,719		3
4	Laundry	53,719	7,615	2,578	63,912		63,912		63,912		4
5	Heat and Other Utilities			114,519	114,519	(1,252)	113,267		113,267		5
6	Maintenance	49,264	4,322	14,141	67,727		67,727	(7,870)	59,857		6
7	Other (specify):*										7
8	TOTAL General Services	326,497	169,498	135,462	631,457	(1,252)	630,205	(8,272)	621,933		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,010,875	37,365	164,569	1,212,809		1,212,809		1,212,809		10
10a	Therapy			1,313	1,313		1,313		1,313		10a
11	Activities	61,040	1,689	3,379	66,108		66,108		66,108		11
12	Social Services	20,855	1,957		22,812		22,812		22,812		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* CHAPLAIN	18,477			18,477		18,477		18,477		15
16	TOTAL Health Care and Programs	1,111,247	41,011	175,261	1,327,519		1,327,519		1,327,519		16
	C. General Administration										
17	Administrative	127,459			127,459		127,459	(12,936)	114,523		17
18	Directors Fees										18
19	Professional Services			48,940	48,940		48,940		48,940		19
20	Dues, Fees, Subscriptions & Promotions			21,933	21,933		21,933	(9,916)	12,017		20
21	Clerical & General Office Expenses	26,367	6,277	10,042	42,686		42,686	(4,885)	37,801		21
22	Employee Benefits & Payroll Taxes			219,861	219,861		219,861		219,861		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,332	3,332		3,332		3,332		24
25	Other Admin. Staff Transportation			1,325	1,325		1,325		1,325		25
26	Insurance-Prop.Liab.Malpractice			100,614	100,614		100,614		100,614		26
27	Other (specify):*										27
28	TOTAL General Administration	153,826	6,277	406,047	566,150		566,150	(27,737)	538,413		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,591,570	216,786	716,770	2,525,126	(1,252)	2,523,874	(36,009)	2,487,865		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PLEASANT HILL HEALTHCARE #0021014 Report Period Beginning: 07/01/07 Ending: 06/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			95,244	95,244		95,244		95,244		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			48,215	48,215		48,215	(2,249)	45,966		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,325	3,325		3,325		3,325		35
36	Other (specify):*										36
37	TOTAL Ownership			146,784	146,784		146,784	(2,249)	144,535		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops					1,252	1,252		1,252		40
41	Coffee and Gift Shops			10,697	10,697		10,697		10,697		41
42	Provider Participation Fee			53,802	53,802		53,802		53,802		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			64,499	64,499	1,252	65,751		65,751		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,591,570	216,786	928,053	2,736,409		2,736,409	(38,258)	2,698,151		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	(402)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,285)	21		5
6	Rented Facility Space	(1,600)	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	(2,249)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,302)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,614)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,452)		\$	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)	(20,806)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,806)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (38,258)		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		1,252	5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,252		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

PLEASANT HILL HEALTHCARE

ID# 0021014

Report Period Beginning: 07/01/07

Ending: 06/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

06/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(402)	0	0	0	0	0	0	0	0	0	0	(402)	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	(7,870)	0	0	0	0	0	0	0	0	0	(7,870)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(402)	(7,870)	0	(8,272)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(12,936)	0	0	0	0	0	0	0	0	0	(12,936)	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	(9,916)	0	0	0	0	0	0	0	0	0	0	(9,916)	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	TOTAL General Administration	(14,801)	(12,936)	0	(27,737)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,203)	(20,806)	0	(36,009)	29								

STATE OF ILLINOIS

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

Summary B

06/30/08

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	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,249)	0	0	0	0	0	0	0	0	0	0	(2,249)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,249)	0	0	0	0	0	0	0	0	0	0	(2,249)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(17,452)	(20,806)	0	(38,258)	45								

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	\$	PLEASANT HILL RESIDENCE		\$	(12,936)	1
2	V	6 MAINTENANCE WAGES		PLEASANT HILL RESIDENCE			(7,870)	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		\$			\$	* (20,806)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE # 0021014 Report Period Beginning: 07/01/07 Ending: 06/30/08

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning: 07/01/07

Ending: 06/30/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HICKORY POINT BANK		X	REFINANCE FACILITY CON	\$3,982.00	10/15/06	\$ 525,081	\$ 492,610	10/15/11	0.0555	\$ 27,928	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	FIRST NATIONAL BANK		X	OPERATING LINE OF CRED	INTEREST	12/28/06	400,050	NONE	12/15/07	0.0850	9,822	6								
7	FIRST NATIONAL BANK		X	OPERATING LINE OF CRED	INTEREST	2/15/08	400,050	264,940	8/31/08	0.0800	10,111	7								
8	VARIOUS VENDORS										354	8								
9	TOTAL Facility Related				\$3,982.00		\$ 1,325,181	\$ 757,550			\$ 48,215	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,325,181	\$ 757,550			\$ 48,215	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT HILL HEALTHCARE 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 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 HEALTHCARE

0021014 Report Period Beginning:

07/01/07 Ending:

06/30/08

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).

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	\$	\$ 788,932	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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	36,398		36,398		539,783	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	\$ 60,798		\$ 60,798	\$	\$ 1,328,715	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

06/30/08

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 12A, Carried Forward		\$ 1,912,193	\$ 60,798		\$ 60,798	\$	\$ 1,328,715	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	TOTAL (lines 1 thru 33)		\$ 2,023,533	\$ 60,798		\$ 60,798	\$	\$ 1,328,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	\$ 60,798		\$ 60,798	\$	\$ 1,328,715	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	SIDEWALK	2008	3,774						10
11	TRANE 5 TON 3 PH ROOFTOP UNIT	2007	5,078						11
12	WINDOW TREATMENT	2007	2,923						12
13	MDM HEAT-COOL	2008	555						13
14	BATHROOM FIXTURES	2008	2,658						14
15	CARPET & COVEBASE	2008	758						15
16	OUTSIDE LIGHTING	2008	371						16
17	REMOTE ANNUCIATOR FOR EMERGENCY GENERATOR	2008	4,097						17
18	HEADS FOR POSTS LIFE SAFETY CODE	2008	354						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)		\$ 2,057,954	\$ 60,798		\$ 60,798	\$	\$ 1,328,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 251,685	\$ 25,074	\$ 25,074	\$	VARIOUS	\$ 187,210	71
72	Current Year Purchases	5,738	467	467		VARIOUS	467	72
73	Fully Depreciated Assets	365,232				VARIOUS	365,232	73
74								74
75	TOTALS	\$ 622,655	\$ 25,541	\$ 25,541	\$		\$ 552,909	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	\$ 268	\$ 268	\$	5	\$ 2,001	76
77	RESIDENT OUTINGS	BUS	2003	57,588	8,637	8,637		5	57,588	77
78										78
79										79
80	TOTALS			\$ 59,589	\$ 8,905	\$ 8,905	\$		\$ 59,589	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 2,768,698	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 95,244	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 95,244	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)		\$ 1,941,213	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,325

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	TOTAL		\$ _____	\$ _____	21

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

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

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>
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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	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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 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	Other (specify):									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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE# 0021014Report Period Beginning: 07/01/07

Ending:

06/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 94,558	\$	1
2	Cash-Patient Deposits	1,380		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 17,163)	347,118		3
4	Supply Inventory (priced at COST)	9,622		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,865		6
7	Other Prepaid Expenses	497		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 463,040	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	28,500		13
14	Buildings, at Historical Cost	1,954,837		14
15	Leasehold Improvements, at Historical Cost	103,622		15
16	Equipment, at Historical Cost	681,739		16
17	Accumulated Depreciation (book methods)	(1,941,213)		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	41,060		21
22	Other Long-Term Assets (spe CAPITAL CONTRIB	68,430		22
23	Other(specify): FARMLAND	60,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,012,717	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,475,757	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 120,566	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,380		28
29	Short-Term Notes Payable	264,940		29
30	Accrued Salaries Payable	68,602		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,883		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,981		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 469,352	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	492,610		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 492,610	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 961,962	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 513,795	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,475,757	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 558,271	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 558,271	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(44,476)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (44,476)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 513,795	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,609,686	1
2	Discounts and Allowances for all Levels	(920)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,608,766	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	11,463	12
13	Barber and Beauty Care	1,252	13
14	Non-Patient Meals	402	14
15	Telephone, Television and Radio	3,285	15
16	Rental of Facility Space	1,600	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,002	23
D. Non-Operating Revenue			
24	Contributions	20,086	24
25	Interest and Other Investment Income***	2,249	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,335	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PHR REIMB 20806; ENDOWMENT FUND 2559	23,365	28
28a	FARM INC 5068; FUND RAISING 14397	19,465	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 42,830	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,691,933	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	631,457	31
32	Health Care	1,327,519	32
33	General Administration	566,150	33
B. Capital Expense			
34	Ownership	146,784	34
C. Ancillary Expense			
35	Special Cost Centers	10,697	35
36	Provider Participation Fee	53,802	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,736,409	40
41	Income before Income Taxes (line 30 minus line 40)**	(44,476)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (44,476)	43

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

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

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

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

Facility Name & ID Number **PLEASANT HILL HEALTHCARE**

0021014

Report Period Beginning: **07/01/07**

Ending:

06/30/08

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	1,666	1,714	\$ 51,678	\$ 30.15	1
2	Assistant Director of Nursing	1,938	2,058	41,629	20.23	2
3	Registered Nurses	2,608	2,686	54,033	20.12	3
4	Licensed Practical Nurses	15,437	16,421	287,040	17.48	4
5	CNAs & Orderlies	55,653	58,512	576,495	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,037	2,138	20,500	9.59	9
10	Activity Assistants	4,884	4,969	40,540	8.16	10
11	Social Service Workers	1,920	2,102	20,855	9.92	11
12	Dietician					12
13	Food Service Supervisor	1,925	2,106	19,751	9.38	13
14	Head Cook	3,051	3,379	28,898	8.55	14
15	Cook Helpers/Assistants	9,777	10,476	88,088	8.41	15
16	Dishwashers	4,067	4,100	31,074	7.58	16
17	Maintenance Workers	3,571	3,847	49,264	12.81	17
18	Housekeepers	6,320	6,739	55,703	8.27	18
19	Laundry	5,728	6,297	53,719	8.53	19
20	Administrator	3,814	4,027	127,459	31.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,968	2,147	26,367	12.28	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	1,251	1,311	18,477	14.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,615	135,029	\$ 1,591,570 *	\$ 11.79	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	132	\$ 4,224	L1,C3	35
36	Medical Director	48	6,000	L9,C3	36
37	Medical Records Consultant	48	1,235	L10,C3	37
38	Nurse Consultant	3	188	L10,C3	38
39	Pharmacist Consultant	24	1,200	L10,C3	39
40	Physical Therapy Consultant	26	1,313	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	3,379	L11,C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	338	\$ 17,539		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	243	8,664	L10,C3	51
52	Certified Nurse Assistants/Aides	7,827	146,352	L10,C3	52
53	TOTAL (lines 50 - 52)	8,070	\$ 155,016		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 2470; LSN 3678
- (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 YRS
- (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. \$ 53,802
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.

SEE ACCOUNTANTS' COMPILATION REPORT

SCHEDULE XI. OWNERSHIP COSTS: PAGE 11

FACILITY GROUNDS CONSIST OF 5.58 ACRES
ORIGINALLY THE LAND WAS SECURED BY DONATION IN 1905 BUT DESIGNATED AS HOME SITE IN 1975
AT WHICH TOME 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.

<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>
VARIOUS EMPLOYEES	7/25/2007	PHV-AUDIO SEMINAR	VARIOUS	AAHSA	89				
G MILLER, C BISHOP	8/15/2007	SPRINGFIELD	ADMIN; RN	IL HEALTHCARE ASSN	150				
GLENN MILLER	8/30/2007	SPRINGFIELD	ADMINISTRATOR	OAKTON COMM COLLE	10				
PAULETTE MILLER	8/16 & 17/07	UTICA	ADMINISTRATOR	LSN			210		82
JANET HOLDEN	11/13/2007	SPRINGFIELD	DON	IL HEALTHCARE ASSN	85				
VIVIAN NANCE	10/18/2007	SPRINGFIELD	C.N.A	SIU SCHOOL OF MED	25				
MACHELLE MARTIN	10/18/2007	SPRINGFIELD	C.N.A	SIU SCHOOL OF MED	25				
GLENN MILLER	10/22/2007	CHICAGO	ADMINISTRATOR	ERCI SEMINAR		36	505	68	
CARMEN BISHOP	11/18/2007	BLOOMINGTON	RN	CROSS COUNTRY ED	179				110
PAULETTE MILLER	11/26/2007	WOODRIDGE	ADMINISTRATOR	LSN	252				
GLENN MILLER	11/30/2007	PHV-AUDIO SEMINAR	ADMINISTRATOR	LSN	199				
GLENN MILLER	1/15/2008	PHV-AUDIO SEMINAR	ADMINISTRATOR	LSN	99				
SHELIA DEWITT	2/15/2008	SPRINGFIELD	LPN	LSN	99				
SARAH STONE	2/20/2008	CARLYLE	ACTIVITY ASST	OUTCOME SERVICES	409				89
SHELIA DEWITT	3/6/2008	SPRINGFIELD	LPN	LSN					32
SARAH STONE	3/20/2008	CARLYLE	ACTIVITY ASST	OUTCOME SERVICES	106				104
PAULETTE MILLER	5/1/2008	PHV-AUDIO SEMINAR	ADMINISTRATOR	LSN	99				
PAULETTE MILLER	6/30/2008	OAKBROOK	ADMINISTRATOR	LSN			151		119
TOTALS					1826	36	866	68	536
GRAND TOTAL									3332