

Facility Name & ID Number Pleasant Meadows Christian Village

0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,748	10,847	4,728	36,323	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,748	10,847	4,728	36,323	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.05%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 1974

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 109 and days of care provided 3,836

Medicare Intermediary Wisconsin Physician Services

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 Meadows Christian Village # 0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	227,885	22,513	33,163	283,561		283,561		283,561		1
2	Food Purchase		249,818		249,818		249,818	(3,427)	246,391		2
3	Housekeeping	184,087	36,352		220,439		220,439		220,439		3
4	Laundry		6,512		6,512		6,512		6,512		4
5	Heat and Other Utilities			178,089	178,089		178,089	9,587	187,676		5
6	Maintenance	56,272	26,520	31,800	114,592		114,592	2,931	117,523		6
7	Other (specify):* Trash Removal			11,423	11,423		11,423		11,423		7
8	TOTAL General Services	468,244	341,715	254,475	1,064,434		1,064,434	9,091	1,073,525		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,168,231	298,670	161,940	2,628,841	(86,392)	2,542,449	(47)	2,542,402		10
10a	Therapy			457,834	457,834		457,834		457,834		10a
11	Activities	37,699			37,699		37,699	(151)	37,548		11
12	Social Services	148,975	157	5,744	154,876		154,876		154,876		12
13	CNA Training										13
14	Program Transportation			3,459	3,459		3,459	(337)	3,122		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,354,905	298,827	640,977	3,294,709	(86,392)	3,208,317	(535)	3,207,782		16
	C. General Administration										
17	Administrative	128,155	1,133	361,476	490,764		490,764	(300,428)	190,336		17
18	Directors Fees										18
19	Professional Services			15,373	15,373		15,373	38,451	53,824		19
20	Dues, Fees, Subscriptions & Promotions			51,265	51,265		51,265	(17,564)	33,701		20
21	Clerical & General Office Expenses	165,152	12,542	81,502	259,196		259,196	76,968	336,164		21
22	Employee Benefits & Payroll Taxes			457,960	457,960		457,960	14,442	472,402		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,511	24,511		24,511	14,838	39,349		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			101,572	101,572		101,572	1,044	102,616		26
27	Other (specify):*										27
28	TOTAL General Administration	293,307	13,675	1,093,659	1,400,641		1,400,641	(172,249)	1,228,392		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,116,456	654,217	1,989,111	5,759,784	(86,392)	5,673,392	(163,693)	5,509,699		29

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

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

Facility Name & ID Number Pleasant Meadows Christian Village #0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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			163,820	163,820		163,820	26,983	190,803		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			98	98		98	(98)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			5,989	5,989		5,989		5,989		35
36	Other (specify):* Purchased Serv./Interest			16,010	16,010		16,010		16,010		36
37	TOTAL Ownership			185,917	185,917		185,917	26,885	212,802		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			88,521	88,521	86,392	174,913		174,913		39
40	Barber and Beauty Shops	19,659	1,107		20,766		20,766		20,766		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,842	59,842		59,842		59,842		42
43	Other (specify):* Apt./Congregate			33,947	33,947		33,947	(33,947)			43
44	TOTAL Special Cost Centers	19,659	1,107	182,310	203,076	86,392	289,468	(33,947)	255,521		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,136,115	655,324	2,357,338	6,148,777		6,148,777	(170,755)	5,978,022		45

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning: 7/1/07

Ending: 6/30/08

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	(3,023)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,396	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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	(9,816)	21		24
25	Fund Raising, Advertising and Promotional	(17,564)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(101,176)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,183)		\$	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)	(52,572)	VII=B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (52,572)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (170,755)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		86,392	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 86,392		47

BHF USE ONLY					
48		49		50	51
					52

Pleasant Meadows Christian Village

ID# 0019166

Report Period Beginning: 7/1/07

Ending: 6/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (404)	2	1
2	Activity	(151)	11	2
3	Transportation	(337)	14	3
4	Miscellaneous	(12)	21	4
5	Late Fees	(32)	6	5
6	Late Fees	(47)	10	6
7	Late Fees	87	21	7
8	Fines and Penalties	(17,837)	21	8
9	Marketing Salaries	(47,668)	21	9
10	Marketing Printing and Supplies	(730)	21	10
11	Apartment/Congregate	(33,947)	43	11
12	Real Estate Taxes for Vacant Lot	(98)	33	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	(101,176)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	(3,427)	0	0	0	0	0	0	0	0	0	0	(3,427)	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	9,587	0	0	0	0	0	0	0	0	0	9,587	5
6	Maintenance	(32)	2,963	0	0	0	0	0	0	0	0	0	2,931	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,459)	12,550	0	9,091	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	(47)	0	0	0	0	0	0	0	0	0	0	(47)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(151)	0	0	0	0	0	0	0	0	0	0	(151)	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	(337)	0	0	0	0	0	0	0	0	0	0	(337)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(535)	0	0	0	0	0	0	0	0	0	0	(535)	16
	C. General Administration													
17	Administrative	0	(300,428)	0	0	0	0	0	0	0	0	0	(300,428)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	38,451	0	0	0	0	0	0	0	0	0	38,451	19
20	Fees, Subscriptions & Promotions	(17,564)	0	0	0	0	0	0	0	0	0	0	(17,564)	20
21	Clerical & General Office Expenses	(75,976)	152,944	0	0	0	0	0	0	0	0	0	76,968	21
22	Employee Benefits & Payroll Taxes	0	14,442	0	0	0	0	0	0	0	0	0	14,442	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,838	0	0	0	0	0	0	0	0	0	14,838	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,044	0	0	0	0	0	0	0	0	0	1,044	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(93,540)	(78,709)	0	(172,249)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(97,534)	(66,159)	0	(163,693)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	13,396	13,587	0	0	0	0	0	0	0	0	0	26,983	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(98)	0	0	0	0	0	0	0	0	0	0	(98)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	13,298	13,587	0	26,885	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):*	(33,947)	0	0	0	0	0	0	0	0	0	0	(33,947)	43
44	TOTAL Special Cost Centers	(33,947)	0	0	0	0	0	0	0	0	0	0	(33,947)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(118,183)	(52,572)	0	(170,755)	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc.	100.00%	\$ 9,587	\$ 9,587
2	V	6 Maintenance				2,963	2,963
3	V	17 Administrative	361,476			61,048	(300,428)
4	V	19 Professional Services				38,451	38,451
5	V	21 Clerical				152,944	152,944
6	V	22 Employee Benefits				14,442	14,442
7	V	26 Insurance				1,044	1,044
8	V	30 Depreciation				13,587	13,587
9	V	24 Travel and Seminars				14,838	14,838
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 361,476			\$ 308,904	\$ * (52,572)

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	This worpaper is not applicable								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning: 7/1/07

Ending: 6/30/08

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

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	Series 2007 Project Fund		X	Renovation Projects		6/30/07	\$ 253,780	\$ 253,780	6/20/2031	0.0560	\$	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 253,780	\$ 253,780			\$	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 253,780	\$ 253,780			\$	15								

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

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

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166 Report Period Beginning: 7/1/07

Ending: 6/30/08

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

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 Meadows Christian Village COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0019166

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. <u>11-03-26-400-021</u>	<u>S26-T16-R12</u>	\$ <u>35.00</u>	\$ _____
2. <u>11-03-26-300-014</u>	<u>S26-T16-R12</u>	\$ <u>63.00</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>98.00</u>	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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 Meadows Christian Village

0019166 Report Period Beginning:

7/1/07 Ending:

6/30/08

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>46,356</u>	<u>1971</u>	<u>\$ 15,876</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>4,893</u>	<u>2</u>
3	TOTALS	46,356		\$ 20,769	3

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	109		1975	1975	\$ 1,305,939	\$ 30,697	40	\$ 32,648	\$ 1,951	\$ 1,020,550	4
5					228,890		20	11,445	11,445		5
6					1,235,805	41,194	30	41,194		350,148	6
7											7
8		Hom Office Allocation			45,550	3,190		3,190		75,725	8
		Improvement Type**									
9		Building Improvements		1979	3,855	84	46	84		2,478	9
10		Building Improvements		1980	533	12	20	12		336	10
11		Contractor A/C		1985	4,298		15			4,298	11
12		Sewer Repairs		1986	2,310	38	20	38		2,348	12
13		Condensing Unit A/C		1986	3,015		10			3,015	13
14		Building Improvements		1987	450		10			450	14
15		Building Improvements		1987	18,430		15			18,430	15
16		Building Improvements		1987	2,258		10			2,258	16
17		Building Improvements		1987	800	3	20	3		800	17
18		Building Improvements		1987	312		10			312	18
19		Building Improvements		1988	1,314		10			1,314	19
20		Building Improvements		1988	3,234		10			3,234	20
21		Building Improvements		1988	3,250		15			3,250	21
22		Building Improvements		1988	20,978		15			20,978	22
23		Phone Lines		1989	1,193		10			1,193	23
24		Wallcovering		1989	2,957		5			2,957	24
25		Wallcovering		1990	1,594		5			1,594	25
26		Reroof Portion of NH		1990	11,305		15			11,305	26
27		Rail/Baseboard		1990	775		10			775	27
28		Wallcovering		1990	1,835		5			1,835	28
29		Wallcovering		1991	1,835		5			1,835	29
30		Wallcovering		1991	5,136		5			5,136	30
31		Rail/Baseboard		1991	744	37	20	37		641	31
32		Wallcovering		1991	848		5			848	32
33		Remodeling		1991	2,996	150	20	150		2,588	33
34		Roof		1991	8,000		15			8,000	34
35		Remodeling		1991	1,720	86	20	86		1,441	35
36		Wallcovering		1991	3,854		5			3,854	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	Sprinkler System	1991	\$ 602	\$	15	\$	\$	\$ 602	37
38	Remodeling	1992	5,488	275	20	275		4,545	38
39	Remodeling	1992	6,610	331	20	331		5,423	39
40	Carpeting	1992	4,115		5			4,115	40
41	Carpeting	1992	8,647		5			8,647	41
42	Door	1992	551		15			551	42
43	Roof	1992	11,500	123	15	123		11,500	43
44	Carpeting	1992	806		5			806	44
45	Wallcovering	1992	3,384		5			3,384	45
46	Wallcovering	1993	3,081		5			3,081	46
47	Carpeting	1993	5,093		5			5,093	47
48	A/C System	1993	11,333	688	15	688		11,333	48
49	Sink	1993	2,199		10			2,199	49
50	Roof-NE/Gutters	1993	15,680	1,045	15	1,045		15,588	50
51	Gutters	1993	990	66	15	66		974	51
52	Baseboard/Wallcoverings	1993	9,755		5			9,755	52
53	10 Ton A/C Unit	1994	9,817	654	15	654		9,210	53
54	Roof Hall	1994	9,600	640	15	640		8,853	54
55	Roof Top	1994	15,088	1,006	15	1,006		13,916	55
56	Gutters	1994	934		10			934	56
57	Rooftop A/C	1994	44,062	2,937	15	2,937		40,139	57
58	Tile Bathrooms	1995	673		5			673	58
59	Kitchen Exhaust Fan	1995	1,680		10			1,680	59
60	Rooftop A/C	1995	7,197		10			7,197	60
61	Bathroom Motion Light	1995	7,299		10			7,299	61
62	Ceramic Tile shower	1995	7,546		10			7,546	62
63	Skylight Dining Room	1995	6,785		10			6,785	63
64	Fire Alarm	1995	1,222		10			1,222	64
65	Wallcoverings	1996	3,300		5			3,300	65
66	Fire Alarm	1996	17,700		10			17,700	66
67	Termite system	1996	11,000	220	20	220		3,722	67
68	Gutters	1996	6,258		10			6,258	68
69	Kick plates	1997	2,743		10			2,743	69
70	TOTAL (lines 4 thru 69)		\$ 3,168,751	\$ 83,476		\$ 96,872	\$ 13,396	\$ 1,780,699	70

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

7/1/07

Ending:

6/30/08

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		\$ 3,168,751	\$ 83,476		\$ 96,872	\$ 13,396	\$ 1,780,699	1
2	Wallcoverings	1997	3,290		5			3,290	2
3	Ventilation Fan	1997	2,167	15	10	15		2,167	3
4	Wallcoverings	1998	8,455		5			8,455	4
5	Rubber Roof Skylight	1998	3,100		5			3,100	5
6	Floor-Therapy room	1998	972		5			972	6
7	Fire Dampers	1999	7,952	795	10	795		7,420	7
8	Alarm System	2000	1,152	115	10	115		1,035	8
9	Quarry Tile	2000	2,033		5			2,033	9
10	Deck	2000	1,271		5			1,271	10
11	3 Ton A/C	2000	1,200		5			1,200	11
12	Deck	2000	719		5			719	12
13	Windows	2000	2,150	215	10	215		1,684	13
14	Wallcoverings	2000	2,792		5			2,792	14
15	Waterline and drain	2001	4,225		5			4,225	15
16	Smoke Detection Unit	2001	2,143	214	10	214		1,427	16
17	Rubber Roof (Northeast Section)	2001	7,737	774	10	774		5,225	17
18	Smoke Detector	2001	3,452	345	10	345		2,271	18
19	Windows	2001	1,923	128	15	128		843	19
20	Build/Install/Finish Fire Doors/Walls	2002	19,377	969	20	969		6,299	20
21	Install Window at Front Reception Desk	2002	967	64	15	64		405	21
22	Implementation of New Structured CAT5E Wiring	2002	1,790	90	20	90		563	22
23	Remove/Hang Wall paper-Beauty Shop Hallway	2002	1,124	112	10	112		681	23
24	65 Gallon AO Smith Water Heater	2002	3,900	390	10	390		2,275	24
25	(6) 11,800 btu A/C units w/wall sleeve	2002	4,016	402	10	402		2,278	25
26	Sanvo Condensing Unit & Evaporator	2003	1,100	110	10	110		559	26
27	Install High EFF Ballast Lights	2003	23,404	2,340	10	2,340		11,895	27
28	Copeland Compressor for Main A/C	2003	1,929	161	12	161		792	28
29	Hubbell Premise Data Cabinet	2003	8,689	579	15	579		2,799	29
30	Hubbell Premise Data Cabinet	2003	10,724	715	15	715		3,456	30
31	Vinyl Wallcoverings - Rooms 316 & 318	2003	2,940	588	5	588		2,695	31
32	Walls in Oxygen Room to Roof Deck	2004	1,459	146	10	146		645	32
33	Install 24 Smoke Detectors	2004	5,730	573	10	573		2,579	33
34	TOTAL (lines 1 thru 33)		\$ 3,312,633	\$ 93,316		\$ 106,712	\$ 13,396	\$ 1,868,749	34

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

7/1/07

Ending:

6/30/08

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		\$ 3,312,633	\$ 93,316		\$ 106,712	\$ 13,396	\$ 1,868,749	1
2	Generator Governor	2003	507	101	5	101		463	2
3	1/2 Payment - Roof NW Wing	2004	9,400	940	10	940		3,760	3
4	Update System to Meet UL300 Fire Code	2005	1,908		3			1,908	4
5	Replace Heat Exchanger on Roof Top Unit	2004	2,112	422	5	422		1,512	5
6	Replace Large Window in Staff Dining Room	2005	2,160	216	10	216		684	6
7	Pella Awning	2005	959	96	10	96		304	7
8	Replace Compressor Kitchen A/C	2005	2,909	888	3	888		2,909	8
9	Cabling Project	2005	1,385	139	10	139		429	9
10	Entry Signs w/Directions	2005	2,825	283	10	283		873	10
11	Land Improvements	1978	18,615		20			18,615	11
12	Shrubs	1981	597		15			597	12
13	Asphalt Work	1984	10,350		15			10,350	13
14	Concrete & Dirt Work	1984	4,779		20			4,779	14
15	Landscaping	1986	6,549		20			6,549	15
16	Burning Bush	1986	96		10			96	16
17	Block Shute & Structure	1988	2,725	136	20	136		2,686	17
18	Resurface Parking Lot	1989	23,325		15			23,325	18
19	Landfill	1989	919		10			919	19
20	Landscaping	1991	2,721	136	20	136		2,346	20
21	Landscaping	1991	981	49	20	49		837	21
22	Water Meter	1991	500		10			500	22
23	Trees	1992	600	30	20	30		482	23
24	Landscaping	1993	2,000	100	20	100		1,500	24
25	Landscaping	1996	1,000		5			1,000	25
26	Resurface Parking Lot	1997	6,000		3			6,000	26
27	Gazebo	2000	6,274	627	10	627		5,643	27
28	Fencing	2000	3,610	361	10	361		3,249	28
29	Landscaping	1999	9,303	930	10	930		8,060	29
30	Fencing	2000	2,200	220	10	220		1,870	30
31	Flowers	2000	705	71	10	71		580	31
32	Flowers	2000	833	83	10	83		678	32
33	Seal Asphalt	2000	3,010	376	8	376		3,008	33
34	TOTAL (lines 1 thru 33)		\$ 3,444,490	\$ 99,520		\$ 112,916	\$ 13,396	\$ 1,985,260	34

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

7/1/07

Ending:

6/30/08

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 12C, Carried Forward		\$ 3,444,490	\$ 99,520		\$ 112,916	\$ 13,396	\$ 1,985,260	1
2	Landscaping	2000	3,564	356	10	356		2,848	2
3	Excavation of Dirt & Grass Seeding	2000	750	75	10	75		581	3
4	Break Up Old & Pour New Sidewalk	2001	665	67	10	67		502	4
5	Parking Lot Lighting	2005	1,988	199	10	199		597	5
6	Asphalt Additional Parking Lot Area	2005	6,395	426	10	426		1,314	6
7	E-Z Barn	1993	1,891	110	15	110		1,891	7
8	Garage	1999	19,001	475	40	475		4,275	8
9	Shed	2000	1,510	151	10	151		1,246	9
10	Electrical Work Outside Lights	2006	1,836	184	10	184		445	10
11	Awning for Ice Cream Parlor	2006	545	55	10	55		137	11
12	(7) PTAC Comfort Series Heat/A	2005	3,675	459	8	459		1,339	12
13	Flooring and Vinyl Fence for Ice	2005	1,560	156	10	156		442	13
14	Concrete Sidewalks Out Exit Doors	2005	5,310	531	10	531		1,505	14
15	Reface Existing Cabinets and Build	2005	1,325	88	15	88		250	15
16	Wallpaper for Skilled Nursing Uni	2006	2,880	576	5	576		1,200	16
17	Addtl Electrical Work on Outside L	2006	840	84	10	84		175	17
18	Lattice Fencing to Improe Entranc	2006	1,035	129	8	129		280	18
19	48 rolls wallpaper - Skilled Unit	2006	955	191	5	191		366	19
20	Code alers system for 3 doors in Haven center	2006	5,460	1,092	5	1,092		2,093	20
21	Wallpaper for Skilled Unit	2006	3,625	725	5	725		1,329	21
22	Replace concrete sidewalks to cooridor exits	2006	2,292	153	15	153		255	22
23	Konecto Prestige Flooring and Installation	2007	9,856	821	10	821		821	23
24	Alcove Enclosure	2007	32,683	2,451	10	2,451		2,451	24
25	Fire Barrier, Life Safety Work	2008	7,652	191	10	191		191	25
26	Install Recessed TV	2008	857	43	5	43		43	26
27	Paint and Prep Walls	2008	675	23	5	23		23	27
28	Install 2 new AC Compressors	2008	2,500	21	10	21		21	28
29	Asphalt Repair and Sealing	2007	13,556	1,412	8	1,412		1,412	29
30	24 Shrubs Installed	2007	2,984	199	8	199		199	30
31	Pond Construction	2008	15,970	665	8	665		665	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,598,325	\$ 111,628		\$ 125,024	\$ 13,396	\$ 2,014,156	34

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	\$ 387,575	\$ 50,240	\$ 50,240	\$	Various	\$ 208,693	71
72	Current Year Purchases	49,116	5,141	5,141		Various	5,142	72
73	Fully Depreciated Assets	476,062				Various	476,062	73
74	Home Office Allocation	133,707	9,363	9,363			21,018	74
75	TOTALS	\$ 1,046,460	\$ 64,744	\$ 64,744	\$		\$ 710,915	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1994 Ford Bus	5/25/1994	\$ 43,500	\$	\$	\$	8	\$ 43,500	76
77	Home Office Allocation			14,780	1,035	1,035			5,621	77
78										78
79										79
80	TOTALS			\$ 58,280	\$ 1,035	\$ 1,035	\$		\$ 49,121	80

E. Summary of Care-Related Assets

	1 Description	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)	\$ 4,723,834	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,407	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 190,803	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,396	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,774,192	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	\$ 95,951	\$ 890	\$ 79,533	86
87	Congregate	446,267	10,217	280,939	87
88	Land	24,818			88
89					89
90					90
91	TOTALS	\$ 567,036	\$ 11,107	\$ 360,472	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 5,167	92
93			93
94			94
95		\$ 5,167	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:	<u>N/A</u>			\$ _____			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: \$ 5,989 Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/07 Ending: 6/30/08

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>Training done at other local businesses including the Hospital and local community college If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	2,243	\$ 144,958	\$	2,243	\$ 144,958	1
2	Licensed Speech and Language Development Therapist		hrs		851	87,396		851	87,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,532	225,385		3,532	225,385	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	6,626	\$ 457,739	\$	6,626	\$ 457,739	14

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning: 7/1/07

Ending:

6/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(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	\$ 1,670,769	\$	1
2	Cash-Patient Deposits	24,765		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 27,209)	746,230		3
4	Supply Inventory (priced at FIFO)	33,138		4
5	Short-Term Investments	2,354		5
6	Prepaid Insurance	1,383		6
7	Other Prepaid Expenses	7,381		7
8	Accounts Receivable (owners or related parties)	231,822		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,717,842	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,694		13
14	Buildings, at Historical Cost	3,936,714		14
15	Leasehold Improvements, at Historical Cost	157,731		15
16	Equipment, at Historical Cost	956,800		16
17	Accumulated Depreciation (book methods)	(3,032,300)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,482,726		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,542,365	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,260,207	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 172,275	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,765		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	327,764		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	156		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other Accrued Liabilities	119,531		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 644,491	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	253,780		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)	\$ 253,780	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 898,271	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,361,936	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,260,207	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,592,317	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,592,317	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(230,381)	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)	\$ (230,381)	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)	\$ 5,361,936	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant Meadows Christian Village# 0019166Report Period Beginning: 7/1/07Ending: 6/30/08**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	\$ 5,909,360	1
2	Discounts and Allowances for all Levels	(1,002,778)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,906,582	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	701,920	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 701,920	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,256	13
14	Non-Patient Meals	3,023	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,304	19
20	Radiology and X-Ray	10,443	20
21	Other Medical Services	14,024	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 66,050	23
D. Non-Operating Revenue			
24	Contributions	102,980	24
25	Interest and Other Investment Income***	86,356	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 189,336	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apartment/Duplex</u>	155,574	28
28a	<u>Unrealized Loss on Investments</u>	(101,066)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 54,508	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,918,396	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,064,434	31
32	Health Care	3,333,907	32
33	General Administration	1,402,004	33
B. Capital Expense			
34	Ownership	185,917	34
C. Ancillary Expense			
35	Special Cost Centers	102,673	35
36	Provider Participation Fee	59,842	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,148,777	40
41	Income before Income Taxes (line 30 minus line 40)**	(230,381)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (230,381)	43

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

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

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

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

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning: 7/1/07

Ending: 6/30/08

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	2,006	2,021	\$ 87,769	\$ 43.43	1
2	Assistant Director of Nursing	1,701	1,836	64,801	35.29	2
3	Registered Nurses	7,732	9,216	240,564	26.10	3
4	Licensed Practical Nurses	25,475	28,369	638,679	22.51	4
5	CNAs & Orderlies	75,806	84,808	917,210	10.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,727	5,137	60,980	11.87	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	9,863	11,283	146,840	13.01	11
12	Dietician					12
13	Food Service Supervisor	1,924	2,101	38,282	18.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,576	20,461	189,603	9.27	15
16	Dishwashers					16
17	Maintenance Workers	3,114	3,379	56,272	16.65	17
18	Housekeepers	16,539	18,943	184,087	9.72	18
19	Laundry					19
20	Administrator	1,815	2,030	140,278	69.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,838	2,030	49,219	24.25	23
24	Clerical	3,613	4,529	55,584	12.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Ward Clerk	3,125	3,365	32,691	9.72	32
33	Other(specify) Community Liasio	13,412	15,067	233,256	15.48	33
34	TOTAL (lines 1 - 33)	190,266	214,575	\$ 3,136,115 *	\$ 14.62	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	656	\$ 31,288	3.1.3	35
36	Medical Director	208	12,000	3.9.3	36
37	Medical Records Consultant	33	1,958	3.10.3	37
38	Nurse Consultant	18	1,292	3.10.3	38
39	Pharmacist Consultant	192	3,103	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	74	5,024	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,181	\$ 54,665		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	987	\$ 43,297	3.10.3	50
51	Licensed Practical Nurses	689	27,417	3.10.3	51
52	Certified Nurse Assistants/Aides	3,433	78,254	3.10.3	52
53	TOTAL (lines 50 - 52)	5,109	\$ 148,968		53

Facility Name & ID Number Pleasant Meadows Christian Village

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$5,689
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,763 Line 3.10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,842
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,023
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.