

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 1/27/2009

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>0</u>	Skilled (SNF)	<u>98</u>	<u>15,190</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>98</u>	Intermediate (ICF)	<u>0</u>	<u>20,580</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>7,625</u>	<u>3,700</u>	<u>153</u>	<u>11,478</u>		8
9	SNF/PED						9
10	ICF	<u>11,061</u>	<u>6,199</u>		<u>17,260</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>18,686</u>	<u>9,899</u>	<u>153</u>	<u>28,738</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.34%

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 3/01/1976

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 98 and days of care provided 153

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2009 Fiscal Year: 6/30/2009

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

Facility Name & ID Number PLEASANT HILL HEALTHCARE # 0021014 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	177,904	11,812	4,224	193,940		193,940		193,940		1
2	Food Purchase		143,067		143,067		143,067	(122)	142,945		2
3	Housekeeping	70,063	11,268		81,331		81,331		81,331		3
4	Laundry	52,248	7,221	2,797	62,266		62,266		62,266		4
5	Heat and Other Utilities			138,457	138,457	(1,697)	136,760		136,760		5
6	Maintenance	53,537	3,879	22,121	79,537		79,537	(7,868)	71,669		6
7	Other (specify):*										7
8	TOTAL General Services	353,752	177,247	167,599	698,598	(1,697)	696,901	(7,990)	688,911		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,136,251	49,869	228,824	1,414,944		1,414,944		1,414,944		10
10a	Therapy			43,902	43,902		43,902		43,902		10a
11	Activities	58,034	2,040	3,602	63,676		63,676		63,676		11
12	Social Services	31,177	1,820		32,997		32,997		32,997		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* CHAPLAIN	19,110			19,110		19,110		19,110		15
16	TOTAL Health Care and Programs	1,244,572	53,729	282,328	1,580,629		1,580,629		1,580,629		16
	C. General Administration										
17	Administrative	101,706			101,706		101,706	(12,848)	88,858		17
18	Directors Fees										18
19	Professional Services			61,163	61,163		61,163		61,163		19
20	Dues, Fees, Subscriptions & Promotions			26,190	26,190		26,190	(13,096)	13,094		20
21	Clerical & General Office Expenses	25,692	7,633	9,477	42,802		42,802	(5,400)	37,402		21
22	Employee Benefits & Payroll Taxes			384,456	384,456		384,456		384,456		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,199	3,199		3,199		3,199		24
25	Other Admin. Staff Transportation			1,554	1,554		1,554		1,554		25
26	Insurance-Prop.Liab.Malpractice			93,394	93,394		93,394		93,394		26
27	Other (specify):*										27
28	TOTAL General Administration	127,398	7,633	579,433	714,464		714,464	(31,344)	683,120		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,725,722	238,609	1,029,360	2,993,691	(1,697)	2,991,994	(39,334)	2,952,660		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			86,189	86,189		86,189		86,189		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			38,109	38,109		38,109	(2,676)	35,433		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,900	3,900		3,900		3,900		35
36	Other (specify):*										36
37	TOTAL Ownership			128,198	128,198		128,198	(2,676)	125,522		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops					1,697	1,697		1,697		40
41	Coffee and Gift Shops			12,652	12,652		12,652		12,652		41
42	Provider Participation Fee			53,655	53,655		53,655		53,655		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			66,307	66,307	1,697	68,004		68,004		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,725,722	238,609	1,223,865	3,188,196		3,188,196	(42,010)	3,146,186		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

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	(122)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,750)	21		5
6	Rented Facility Space	(1,650)	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	(2,676)	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	(7,138)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,958)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,294)		\$	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)	(20,716)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,716)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (42,010)		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		1,697	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)			\$ 1,697		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

PLEASANT HILL HEALTHCARE

ID# 0021014

Report Period Beginning: 07/01/08

Ending: 06/30/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	(122)	0	0	0	0	0	0	0	0	0	0	(122)	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	(7,868)	0	0	0	0	0	0	0	0	0	(7,868)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(122)	(7,868)	0	(7,990)	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	(12,848)	0	0	0	0	0	0	0	0	0	(12,848)	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	(13,096)	0	0	0	0	0	0	0	0	0	0	(13,096)	20
21	Clerical & General Office Expenses	(5,400)	0	0	0	0	0	0	0	0	0	0	(5,400)	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	(18,496)	(12,848)	0	(31,344)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,618)	(20,716)	0	(39,334)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT HILL HEALTHCARE# 0021014

Report Period Beginning:

07/01/08 Ending:06/30/09

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

	Capital Expense	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)	
	D. Ownership													
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	(2,676)	0	0	0	0	0	0	0	0	0	0	(2,676)	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	(2,676)	0	0	0	0	0	0	0	0	0	0	(2,676)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(21,294)	(20,716)	0	(42,010)	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
N/A	N/A	N/A		PLEASANT HILL		INDEPENDENT
				RESIDENCE	GIRARD	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		\$		(12,848) 1
2	V	6 MAINTENANCE WAGES		PLEASANT HILL RESIDENCE				(7,868) 2
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$			\$	\$ *	(20,716) 14

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

Facility Name & ID Number PLEASANT HILL HEALTHCARE # 0021014 Report Period Beginning: 07/01/08 Ending: 06/30/09

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:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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

Facility Name & ID Number

PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/08

Ending:

06/30/09

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										
										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	\$6,187.00	10/15/08	\$ 525,081	\$ 462,757	10/15/24	0.0555	\$ 25,957	1							
2	CNH CAPITAL		X	PURCHASE TRACTOR & LO	\$318.00	1/28/09	15,246	13,658	1/28/13	0.0000		2							
3												3							
4												4							
5												5							
Working Capital																			
6	FIRST NATIONAL BANK		X	OPERATING LINE OF CREDI	INTEREST	2/15/08	400,050	NONE	8/31/08	0.0800	2,896	6							
7	FIRST NATIONAL BANK		X	OPERATING LINE OF CREDI	INTEREST	8/31/08	400,050	64,500	8/31/09	0.0700	8,821	7							
8	VARIOUS VENDORS		X								435	8							
9	TOTAL Facility Related				\$6,505.00		\$ 1,340,427	\$ 540,915			\$ 38,109	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,340,427	\$ 540,915			\$ 38,109	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.)

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/08

Ending:

06/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000 B. General Construction Type: Exterior BRICK Frame STEEL & FIRE RESIS 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY & GROUNDS</u>	<u>243,065</u>	<u>1905-1975*</u>	<u>\$ 28,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	243,065		\$ 28,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		1976	1976	\$ 975,998	\$ 24,400	40	\$ 24,400	\$	\$ 813,332	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	37,712		37,712		577,498	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 & PAP		1995	40,250						26
27		DRIVEWAY, ARCHITECH, LANDSCAPING, A/C WINDOW TREATM		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:

07/01/08

Ending:

06/30/09

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	\$ 62,112		\$ 62,112	\$	\$ 1,390,830	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:

07/01/08

Ending:

06/30/09

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	\$ 62,112		\$ 62,112	\$	\$ 1,390,830	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 CONDENCER	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	\$ 62,112		\$ 62,112	\$	\$ 1,390,830	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:

07/01/08

Ending:

06/30/09

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	\$ 62,112		\$ 62,112	\$	\$ 1,390,830	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 ANNUNCIATOR FOR EMERGENCY GENERATOR	2008	4,097						17
18	HEADS FOR POSTS LIFE SAFETY CODE	2008	354						18
19	REPLACE SHINGLES ON 2 WINGS	2008	3,144						19
20	HEAT & COOL SYSTEM	2008	564						20
21	WINDOW TREATMENT	2008	4,024						21
22	PLUMBING TO CODE	2008	9,702						22
23	CEILING TILE	2008	582						23
24	ELECTRICAL WORK	2008	2,830						24
25	BATHROOM FIXTURES	2009	725						25
26	RAILING BETWEEN BUILDINGS	2009	1,699						26
27	5 TON COMPRESSOR UNIT	2009	2,683						27
28	HEAT & COOL SYSTEM	2009	614						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,084,521	\$ 62,112		\$ 62,112	\$	\$ 1,390,830	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	\$ 229,254	\$ 21,683	\$ 21,683	\$	VARIOUS	\$ 181,191	71
72	Current Year Purchases	39,001	2,394	2,394		VARIOUS	2,394	72
73	Fully Depreciated Assets	393,401				VARIOUS	393,401	73
74								74
75	TOTALS	\$ 661,656	\$ 24,077	\$ 24,077	\$		\$ 576,986	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	RESIDENT OUTINGS	BUS	2003	\$ 57,588	\$	\$	\$	5	\$ 57,588	76
77										77
78										78
79										79
80	TOTALS			\$ 57,588	\$	\$	\$		\$ 57,588	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)	\$ 2,832,265	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,189	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,189	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)	\$ 2,025,404	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.

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

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? _____

16. Rental Amount for movable equipment: \$ 3,900 Description: OFFICE COPIER YES NO

(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

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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>AIDES WERE ALREADY TRAINED</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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	L10A;C3	hrs	\$	1,436	\$ 30,115	\$	1,436	\$ 30,115	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A;C3	hrs		620	12,974		620	12,974	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			\$	2,056	\$ 43,089	\$	2,056	\$ 43,089	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 128,309	\$	1
2	Cash-Patient Deposits	8,050		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,363)	310,303		3
4	Supply Inventory (priced at COST)	9,786		4
5	Short-Term Investments			5
6	Prepaid Insurance	36,043		6
7	Other Prepaid Expenses	1,472		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 493,963	\$	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	1,981,404		14
15	Leasehold Improvements, at Historical Cost	108,695		15
16	Equipment, at Historical Cost	718,739		16
17	Accumulated Depreciation (book methods)	(2,025,404)		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	39,195		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)	\$ 995,301	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,489,264	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 250,301	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,050		28
29	Short-Term Notes Payable	64,500		29
30	Accrued Salaries Payable	119,911		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,187		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)	\$ 443,949	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	13,658		39
40	Mortgage Payable			40
41	Bonds Payable	462,757		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)	\$ 476,415	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 920,364	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 568,900	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,489,264	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 513,795	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 513,795	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 55,105	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)	\$ 55,105	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)	\$ 568,900	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning: 07/01/08

Ending: 06/30/09

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	\$ 3,154,288	1
2	Discounts and Allowances for all Levels	(550)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,153,738	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	16,303	12
13	Barber and Beauty Care	1,697	13
14	Non-Patient Meals	122	14
15	Telephone, Television and Radio	3,750	15
16	Rental of Facility Space	1,650	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)	\$ 23,522	23
D. Non-Operating Revenue			
24	Contributions	18,369	24
25	Interest and Other Investment Income***	2,676	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,045	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PHR REIMB 20,716; ENDOWMENT FUND 2,265	22,981	28
28a	FARM INC 3,535; FUND RAISING 18,480	22,015	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 44,996	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,243,301	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	698,598	31
32	Health Care	1,580,629	32
33	General Administration	714,464	33
B. Capital Expense			
34	Ownership	128,198	34
C. Ancillary Expense			
35	Special Cost Centers	12,652	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,188,196	40
41	Income before Income Taxes (line 30 minus line 40)**	55,105	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,105	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 07/01/08

Ending:

06/30/09

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	1,811	1,811	\$ 57,874	\$ 31.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,115	3,296	75,347	22.86	3
4	Licensed Practical Nurses	19,741	20,827	381,189	18.30	4
5	CNAs & Orderlies	59,479	62,593	621,841	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,487	1,613	13,337	8.27	9
10	Activity Assistants	5,148	5,486	44,697	8.15	10
11	Social Service Workers	2,684	2,814	31,177	11.08	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,181	21,576	9.89	13
14	Head Cook	5,289	5,787	51,191	8.85	14
15	Cook Helpers/Assistants	5,159	5,499	47,610	8.66	15
16	Dishwashers	6,856	6,968	57,527	8.26	16
17	Maintenance Workers	3,708	4,004	53,537	13.37	17
18	Housekeepers	7,732	8,179	70,063	8.57	18
19	Laundry	5,579	5,982	52,248	8.73	19
20	Administrator	3,744	3,760	101,706	27.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,958	2,217	25,692	11.59	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	1,189	1,299	19,110	14.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,668	144,316	\$ 1,725,722 *	\$ 11.96	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	36	929	L10;C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	L10;C3	39
40	Physical Therapy Consultant	16	813	L10A;C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	3,602	L11;C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	312	\$ 16,768		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	16	616	L10;C3	51
52	Certified Nurse Assistants/Aides	10,907	211,631	L10;C3	52
53	TOTAL (lines 50 - 52)	10,923	\$ 212,247		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	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
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

Facility Name & ID Number PLEASANT HILL HEALTHCARE

0021014

Report Period Beginning: 07/01/08

Ending: 06/30/09

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 2113; LSN 4383
- (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. \$ 53,655
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NO
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
- (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.

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>
BECKY PIERSON	7/22/2008	JACKSONVILLE	DIETARY SUPER	LSN	85				28
DIANA SCHMIDT	7/29/2008	CARLYLE	ACTIVITY DIRECTOR	OUTCOME SERVICES	65				
NICKIE, LITTLE	9/16/2008	HILLSBORO	RN	MONTGOMERY CO CPF	150				
PAULETTE MILLER	9/16/2008	BLOOMINGTON	EXECTIVE DIR	LSN	70				
KRISTINA SPOOR	10/20/2008	GIRARD	ACTIVITY DIRECTOR	OUTCOME SERVICES	400				
PAULETTE MILLER	10/23/2008	CHICAGO	EXECTIVE DIR	FALL FORUM RISK MGMT			552	99	
PAULETTE MILLER	11/14/2008	PEORIA	EXECTIVE DIR	BRETHREN DIST CONF			83		62
DONNA WHITEHEAD	11/26/2008	GIRARD	ADMINISTRATOR	LSN	99				
DONNA WHITEHEAD	1/19/2009	GIRARD	ADMINISTRATOR	LSN	99				
DONNA WHITEHEAD	2/18/2009	SPRINGFIELD	ADMINISTRATOR	LSN	85				
ALL RNS AND ALL LPNS	2/28/2009	GIRARD	RNS & LPNS	ENLOE DRUGS, INC	975				
DONNA WHITEHEAD	5/11/2009	GIRARD	ADMINISTRATOR	LSN	99				
CARMEN, BISHOP	5/15/2009	SPRINGFIELD	RN	SIU SCHOOL OF MEDIC	50				
DONNA WHITEHEAD	5/18/2009	GIRARD	ADMINISTRATOR	LSN FOUNDATION	99				
PAULETTE MILLER	5/26/2009	GIRARD	EXECTIVE DIR	LSN FOUNDATION	99				

TOTALS

2375

0

635

99

90

GRAND TOTAL

3199