

Facility Name & ID Number Pleasant Meadows Christian Village

0019166 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	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	39,785	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	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	21,484	8,170	4,654	34,308	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,484	8,170	4,654	34,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.23%

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 3,891

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	301,216	30,602	4,887	336,705		336,705		336,705		1
2	Food Purchase		263,974		263,974		263,974	(1,358)	262,616		2
3	Housekeeping	181,920	36,951		218,871		218,871		218,871		3
4	Laundry		5,538		5,538		5,538		5,538		4
5	Heat and Other Utilities			204,793	204,793		204,793	9,357	214,150		5
6	Maintenance	53,185	17,803	37,675	108,663		108,663	2,176	110,839		6
7	Other (specify):* Trash			11,477	11,477		11,477		11,477		7
8	TOTAL General Services	536,321	354,868	258,832	1,150,021		1,150,021	10,175	1,160,196		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,275,782	252,269	163,025	2,691,076	(98,142)	2,592,934	(1)	2,592,933		10
10a	Therapy			482,746	482,746		482,746		482,746		10a
11	Activities	101,928			101,928		101,928	(332)	101,596		11
12	Social Services	81,100	2,154	36,214	119,468		119,468		119,468		12
13	CNA Training										13
14	Program Transportation			3,991	3,991		3,991	(738)	3,253		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,458,810	254,423	697,976	3,411,209	(98,142)	3,313,067	(1,071)	3,311,996		16
	C. General Administration										
17	Administrative	212,002	2,452	360,156	574,610		574,610	(299,597)	275,013		17
18	Directors Fees										18
19	Professional Services			2,593	2,593		2,593	27,957	30,550		19
20	Dues, Fees, Subscriptions & Promotions			55,058	55,058		55,058		55,058		20
21	Clerical & General Office Expenses	158,427	21,637	61,435	241,499		241,499	169,158	410,657		21
22	Employee Benefits & Payroll Taxes			525,989	525,989		525,989	25,878	551,867		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,557	19,557		19,557	11,894	31,451		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			109,152	109,152		109,152	1,391	110,543		26
27	Other (specify):* Marketing	59,144	1,262	23,113	83,519		83,519	(83,519)			27
28	TOTAL General Administration	429,573	25,351	1,157,053	1,611,977		1,611,977	(146,838)	1,465,139		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,424,704	634,642	2,113,861	6,173,207	(98,142)	6,075,065	(137,734)	5,937,331		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.

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			173,113	173,113		173,113	16,300	189,413			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,252	14,252		14,252	(12,493)	1,759			32
33	Real Estate Taxes			104	104		104	(104)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,373	17,373		17,373		17,373			35
36	Other (specify):* Gift Shop			36	36		36		36			36
37	TOTAL Ownership			204,878	204,878		204,878	3,703	208,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			87,248	87,248	98,142	185,390		185,390			39
40	Barber and Beauty Shops	21,926	1,270	40	23,236		23,236		23,236			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):* Apt./Congregate			38,539	38,539		38,539	(38,539)				43
44	TOTAL Special Cost Centers	21,926	1,270	185,505	208,701	98,142	306,843	(38,539)	268,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,446,630	635,912	2,504,244	6,586,786		6,586,786	(172,570)	6,414,216			45

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

Pleasant Meadows Christian Village

ID# 0019166

Report Period Beginning: 7/1/08

Ending: 6/30/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending	\$ 410	2	1
2	Activity	(332)	11	2
3	Transportation	(738)	14	3
4	Miscellaneous	(40)	21	4
5	Late Fees	(133)	6	5
6	Late Fees	(1)	10	6
7	Fines and Penalties	3,350	21	7
8	Apartment/Congregate	(38,539)	43	8
9	Real Estate Taxes for Vacant Lot	(104)	33	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	(36,127)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant Meadows Christian Village

0019166

Report Period Beginning:

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,358)	0	0	0	0	0	0	0	0	0	0	(1,358)	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	9,357	0	0	0	0	0	0	0	0	0	9,357	5
6	Maintenance	(133)	2,309	0	0	0	0	0	0	0	0	0	2,176	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,491)	11,666	0	10,175	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	(1)	0	0	0	0	0	0	0	0	0	0	(1)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(332)	0	0	0	0	0	0	0	0	0	0	(332)	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	(738)	0	0	0	0	0	0	0	0	0	0	(738)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,071)	0	0	0	0	0	0	0	0	0	0	(1,071)	16
	C. General Administration													
17	Administrative	0	(299,597)	0	0	0	0	0	0	0	0	0	(299,597)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,957	0	0	0	0	0	0	0	0	0	27,957	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	108	169,050	0	0	0	0	0	0	0	0	0	169,158	21
22	Employee Benefits & Payroll Taxes	0	25,878	0	0	0	0	0	0	0	0	0	25,878	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	11,894	0	0	0	0	0	0	0	0	0	11,894	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	1,391	0	0	0	0	0	0	0	0	0	1,391	26
27	Other (specify):*	(83,519)	0	0	0	0	0	0	0	0	0	0	(83,519)	27
28	TOTAL General Administration	(83,411)	(63,427)	0	(146,838)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,973)	(51,761)	0	(137,734)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

Pleasant Meadows Christian Village

0019166

Report Period Beginning:

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Ending:

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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	16,300	0	0	0	0	0	0	0	0	0	16,300	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,252)	1,759	0	0	0	0	0	0	0	0	0	(12,493)	32
33	Real Estate Taxes	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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	(14,356)	18,059	0	3,703	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):*	(38,539)	0	0	0	0	0	0	0	0	0	0	(38,539)	43
44	TOTAL Special Cost Centers	(38,539)	0	0	0	0	0	0	0	0	0	0	(38,539)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(138,868)	(33,702)	0	(172,570)	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 for 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%	\$ 9,357	\$ 9,357	1
2	V	6 Maintenance				2,309	2,309	2
3	V	17 Administrative	360,156			60,559	(299,597)	3
4	V	19 Professional Services				27,957	27,957	4
5	V	21 Clerical				169,050	169,050	5
6	V	22 Employee Benefits				25,878	25,878	6
7	V	26 Insurance				1,391	1,391	7
8	V	30 Depreciation				16,300	16,300	8
9	V	24 Travel and Seminars				11,894	11,894	9
10	V	32 Interest				1,759	1,759	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 360,156			\$ 326,454	\$ * (33,702)	14

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

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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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	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

Facility Name & ID Number

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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	Series 2007 Project Fund	X	Renovation Projects		6/30/07	\$ 253,780	\$ 253,780	6/20/2031	0.0560	\$ 14,252	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			\$ 14,252	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			\$ 14,252	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.)

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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:

	1	2	3	4	
A. Land.	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>5,023</u>	<u>2</u>
3	TOTALS	46,356		\$ 20,899	3

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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	109		1975	1975	\$ 1,305,939	\$ 31,866	40	\$ 31,866	\$	\$ 1,054,249	4
5					228,890		20				5
6					1,235,805	41,194	30	41,194		391,338	6
7											7
8		Home Office Allocation			47,709	3,494		3,494		89,861	8
		Improvement Type**									
9		75 Amp Contractor AC		7/4/1985	4,298		15			4,298	9
10		Building 1979		6/30/1979	3,855	84	46	84		2,521	10
11		Sewer Repair		12/31/1986	2,310		20			2,310	11
12		Wall coverings		12/11/1990	1,835		5			1,835	12
13		Chair Rail & Baseboard System		11/23/1990	775		10			775	13
14		Sprinkler System		12/27/1991	602		15			602	14
15		Wall coverings		11/11/1992	3,384		5			3,384	15
16		Baseboards chair rail		11/29/1993	926		5			926	16
17		Wall coverings		12/20/1993	6,067		5			6,067	17
18		door		6/30/1980	533	12	44	12		352	18
19		Wall coverings		12/10/1991	1,927		5			1,927	19
20		Wall coverings		12/1/1991	1,927		5			1,927	20
21		TileBathrooms		1/6/1995	673		5			673	21
22		Gutters		11/21/1996	6,258		10			6,258	22
23		Wall coverings		12/15/2000	2,792		5			2,792	23
24		Land Improvements 1978		6/30/1978	18,615		20			18,615	24
25		Shrubs		4/30/1981	597		15			597	25
26		Condensing unit AC		6/9/1986	3,015		10			3,015	26
27		Landscaping		6/30/1986	6,549		20			6,549	27
28		Burning Bush		11/17/1986	96		10			96	28
29		Asphalt Work		7/31/1984	10,350		15			10,350	29
30		Concrete & dirt work		8/31/1984	4,779		20			4,779	30
31		Rubbber Roof Ac Unit		7/31/1987	450		10			450	31
32		3 ton Condensina Unit		7/31/1987	2,256		10			2,258	32
33		Rewiring		8/31/1987	800		20			800	33
34		HeatingAC Equipment		8/31/1987	312		10			312	34
35		Electric Heat units (6)		1/14/1988	3,234		10			3,234	35
36		Ceiling & entry Work		6/12/1988	3,250		15			3,250	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:

7/1/08

Ending:

6/30/09

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	Reroofing 3 sections	6/30/1988	\$ 20,978	\$	15	\$	\$	\$ 20,978	37
38	inst Condensing unit	6/30/1988	1,314		10			1,314	38
39	Block Shute & Structure	10/6/1988	2,725	34	20	34		2,725	39
40	Phone Lines	2/20/1989	1,193		10			1,193	40
41	Resurphace Parking Lot	6/30/1989	23,325		15			23,325	41
42	Landfill	6/30/1989	919		10			919	42
43	Wallcoverings	1/30/1990	2,957		5			2,957	43
44	Wallcoverings	3/28/1990	1,594		5			1,594	44
45	reproff portion of nursing home	6/12/1990	11,305		15			11,305	45
46	Wallcoverings	2/21/1991	5,136		5			5,136	46
47	Wallcoverings	3/27/1991	848		5			848	47
48	landscaping	4/24/1991	2,721	136	20	136		2,483	48
49	landscaping	6/30/1991	981	49	20	49		887	49
50	Water Meter	6/26/1991	500		10			500	50
51	Remodeling	4/10/1991	2,996	150	20	150		2,734	51
52	Remodeling	1/27/1992	3,493	175	20	175		3,056	52
53	Carpeting	2/17/1992	4,115		5			4,115	53
54	Remodeling (5 Rooms)	2/27/1992	1,995	100	20	100		1,737	54
55	Carpetcove Base	6/30/1992	8,647		5			8,647	55
56	Oak Doorsteel Frame	7/13/1992	551		15			551	56
57	Trees	6/25/1992	600	30	20	30		513	57
58	Wallcoverings	2/18/1993	3,081		5			3,081	58
59	carpeting	5/24/1993	5,093		5			5,093	59
60	EZ Barn	5/20/1993	1,891		15			1,891	60
61	3 Cmpt. Sink	6/30/1993	2,199		10			2,199	61
62	landscaping	7/6/1993	2,000	100	20	100		1,600	62
63	Wallcoverings	2/24/1994	2,762		5			2,762	63
64	(7) PTAC Confort Series HeatAC Room Units	8/31/2005	3,675	459	8	459		1,799	64
65	Flooring and Vinyl Fence for Ice Cream	9/22/2005	1,560	156	10	156		598	65
66	Concrete Sidewalks out Exit Doors	9/7/2005	5,310	531	10	531		2,036	66
67	Reface Existing cabinets and Build new	9/1/2005	1,325	88	15	88		339	67
68	AC 10 Ton unit	6/30/1994	9,817	600	15	600		9,817	68
69	Rooftop AC (5)	9/22/1994	15,088	1,006	15	1,006		14,920	69
70	TOTAL (lines 4 thru 69)		\$ 3,063,502	\$ 80,264		\$ 80,264	\$	\$ 1,770,052	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:

7/1/08

Ending:

6/30/09

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		\$ 3,063,502	\$ 80,264		\$ 80,264	\$	\$ 1,770,052	1
2	Kitchen Exhaust Fan	5/23/1995	1,680		10			1,680	2
3	Rooftop Air Conditioner	5/23/1995	7,197		10			7,197	3
4	Bathroom motion light	5/23/1995	7,299		10			7,299	4
5	Ceramic Tile shower Room	6/26/1995	7,546		10			7,546	5
6	Skylight dining Room	8/14/1995	6,785		10			6,785	6
7	Wallcoverings K Bath	1/18/1996	3,300		5			3,300	7
8	Wall Coverings	2/6/1991	1,835		5			1,835	8
9	Fire Alarm	4/22/1996	17,700		10			17,700	9
10	Termite System	5/14/1996	11,000	220	50	220		2,897	10
11	landscaping	8/29/1996	1,000		5			1,000	11
12	kick Plates	1/24/1997	2,743		10			2,743	12
13	Wall coverngT Bath	1/30/1997	3,290		5			3,290	13
14	Ventilation Fan	8/11/1997	2,167		10			2,167	14
15	Resurface Parking Lot	9/26/1997	6,000		3			6,000	15
16	Carpeting	10/13/1992	806		5			806	16
17	Wallcovering	2/26/1998	8,455		5			8,455	17
18	Floortherapy Room	6/26/1998	972		5			972	18
19	Fencing	1/5/2000	3,610	361	10	361		3,430	19
20	Landscaping	11/8/2009	9,303	930	10	930		8,993	20
21	Gazebo	1/5/2000	6,274	627	10	627		5,960	21
22	Fencing	1/5/2000	2,200	220	10	220		2,090	22
23	AC 3 Ton	7/11/2000	1,200		5			1,200	23
24	Deck	7/13/2000	719		5			719	24
25	Seal Asphalt	7/28/2000	3,010		8			3,010	25
26	landscaping	7/27/2000	3,564	356	10	356		3,208	26
27	Excavation of Drit & Seeding of Grass	10/17/2000	750	75	10	75		656	27
28	Waterline & Drain	7/25/2001	4,225		5			4,225	28
29	Build Install & Finish Fire Doorswalls	1/14/2002	19,377	969	20	969		7,266	29
30	Install Window @ Front Recept Desk	3/29/2002	967	64	15	64		473	30
31	Inplemtation of New Structured Cat5E	4/27/2002	1,790	90	20	90		649	31
32	Break Up Old & Pour New Sidewalk	11/26/2001	665	67	10	67		510	32
33	Remove & Hang New Wallpaper beauty Shop	6/3/2002	1,124	112	10	112		796	33
34	TOTAL (lines 1 thru 33)		\$ 3,212,055	\$ 84,355		\$ 84,355	\$	\$ 1,894,909	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:

7/1/08

Ending:

6/30/09

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		\$ 3,212,055	\$ 84,355		\$ 84,355	\$	\$ 1,894,909	1
2	(6) 11800 BTU AC Units Wwall Sleece &	11/30/2002	4,016	402	10	402		2,677	2
3	Roofing	10/30/1987	18,430		15			18,430	3
4	Rubber Roof Skylight	4/8/1998	3,100		5			3,100	4
5	Deck	6/27/2000	1,271		5			1,271	5
6	Install High Eff Ballast Lights	6/27/2003	23,404	2,340	10	2,340		14,237	6
7	Install 24 Smoke Detecors	1/26/2004	5,730	573	10	573		3,152	7
8	Roof Northwest Wing	7/1/2004	9,400	940	10	940		4,700	8
9	Gutters	10/31/1994	934		10			934	9
10	Repl Heat Exchanger on roof top unit	12/29/2004	2,112	422	5	422		1,936	10
11	Replace LG Window in Staff Din Roof	5/11/2005	2,160	216	10	216		900	11
12	Pella Awning	5/11/2005	959	96	10	96		400	12
13	Flowers	5/22/2000	705	71	10	71		646	13
14	flowers	5/16/2000	833	83	10	83		764	14
15	Shed	4/3/2000	1,510	151	10	151		1,397	15
16	Cabling Project	6/9/2005	1,385	139	10	139		566	16
17	Entry signs W Directions	6/5/2005	2,825	283	10	283		1,154	17
18	Window	9/5/2000	2,150	215	10	215		1,899	18
19	Fire Alarm	10/26/1995	1,222		10			1,222	19
20	48 rolls wallpaper Skilled unit	8/11/2006	955	191	5	191		557	20
21	Code alert system for 3 doors in Haven	8/9/2006	5,460	1,092	5	1,092		3,185	21
22	Wallpaper for Skilled Unit	9/1/2006	3,625	725	5	725		2,054	22
23	Roof (3 Sections)	9/6/1991	8,000		15			8,000	23
24	Lomectp Prestige Flooring Installation	9/1/2007	9,856	986	10	986		1,807	24
25	Asphalt Repair & Sealing	9/17/2007	13,556	1,695	8	1,695		3,107	25
26	RoofNorth Section	9/2/1992	11,500		15			11,500	26
27	Fire Barrier Life Safety Work	4/10/2008	7,652	765	10	765		956	27
28	Install Recessed TV	4/10/2008	857	171	5	171		214	28
29	Paint & Prep Walls	5/20/2008	675	135	5	135		158	29
30	AC System	6/4/1993	11,333		15			11,333	30
31	Install 2 AC New Compressors	6/9/2008	2,500	250	10	250		271	31
32	RoofNorthEast Section	8/5/1993	15,680	87	15	87		15,680	32
33	Hubbell Premise Data Cabinet	9/25/2003	8,689	579	15	579		3,379	33
34	TOTAL (lines 1 thru 33)		\$ 3,394,539	\$ 96,962		\$ 96,962	\$	\$ 2,016,495	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:

7/1/08

Ending:

6/30/09

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 12C, Carried Forward		\$ 3,394,539	\$ 96,962		\$ 96,962		\$ 2,016,495	1
2	Hubble Premise Data Cabinet	9/15/2003	10,724	715	15	715		4,170	2
3	New Air Compressor for Dry Fire System	9/30/2008	708	59	10	59		59	3
4	Roof Work	9/21/2008	16,700	1,392	10	1,392		1,392	4
5	Gutters	10/7/1993	990	17	15	17		990	5
6	Fire Dampers	3/18/1999	7,952	530	10	530		7,952	6
7	Door monitor Equipment	3/18/2009	5,887	196	10	196		196	7
8	13 Handicapped Stools w. Lids	3/1/2009	2,445	81	10	81		81	8
9	Awning for Ice Cream Parlor	1/23/2006	545	54	10	54		191	9
10	Electrical work Outside Lights	2/1/2006	1,836	184	10	184		627	10
11	Chair Rail & Baseboard	3/6/1991	744	37	20	37		682	11
12	Remodeling	10/1/1991	1,720	86	20	86		1,527	12
13	Remodeling	12/27/1991	1,995	100	20	100		1,754	13
14	remodeling (5 Rooms)	2/4/1992	1,995	100	20	100		1,737	14
15	remodeling	3/6/1992	625	31	20	31		542	15
16	remodeling	3/3/1992	1,995	100	20	100		1,729	16
17	Roofhall 4 skilled	9/8/1994	9,600	640	15	640		9,493	17
18	Rooftop AC (2)	11/28/1994	44,062	2,937	15	2,937		43,083	18
19	Alarm System	7/1/1999	1,152	115	10	115		1,152	19
20	Quarry Tile	9/20/1999	2,033		5			2,033	20
21	Smoke detection unit	11/29/2001	2,143	214	10	214		1,643	21
22	Rubber Roofing (Northeast Section)	10/24/2001	7,737	774	10	774		5,996	22
23	Smoke detector	12/13/2001	3,452	345	10	345		2,618	23
24	Windows	12/6/2001	1,923	128	15	128		972	24
25	Sanyo Condensing Unit& Evaporator	6/5/2003	1,100	110	10	110		669	25
26	Copeland Compressor For Main AC	8/20/2003	1,929	161	12	161		951	26
27	Vinyl Wallcoverings 316 & 318	12/18/2003	2,940	245	5	245		2,940	27
28	Walls in Oxygen room to roof deck	2/16/2004	1,459	146	10	146		790	28
29	Generator Governor	12/12/2003	507	42	5	42		507	29
30	Update sys to meet UL300 Fire Code	1/14/2005	1,908		3			1,908	30
31	Replace Compressor Kitchen Compressor Kitchen AC	6/17/2005	2,909		3			2,909	31
32	Wallpaper for Skilled Nursing Unit	6/23/2006	2,880	576	5	576		1,776	32
33	Alcove enclosure and Construction of n	10/1/2007	32,683	3,268	10	3,268		5,720	33
34	TOTAL (lines 1 thru 33)		\$ 3,571,817	\$ 110,345		\$ 110,345		\$ 2,125,284	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:

7/1/08

Ending:

6/30/09

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 12D, Carried Forward		\$ 3,571,817	\$ 110,345		\$ 110,345	\$	\$ 2,125,284	1
2	65 Gallon Water Heatefr	7/17/2008	6,183	618	10	618			2
3	Install 9 Cable runs	7/10/2008	1,161	116	10	116			3
4	Install 42x54 glass	5/1/2009	515	9	10	9			4
5	Install 49x61glass	5/1/2009	615	10	10	10			5
6	Parking Lot Lighting	5/31/2005	1,988	199	10	199			6
7	Asphalt Additional Parking Lot	6/29/2005	6,395	426	15	426			7
8	Addtl Electrical work on Outside light	6/27/2006	840	84	10	84			8
9	Lattice Fencing ito Improve Entrance Appearance	5/5/2006	1,035	129	8	129			9
10	Replace Concrete sidewalks to corridor	11/28/2006	2,292	153	15	153			10
11	Install (24) shrubs landscape front ar	11/8/2007	2,984	298	10	298			11
12	Landscaping Project - Pond Construction	2/1/2008	15,970	1,597	10	1,597			12
13	Garage	7/1/1999	19,001	475	40	475			13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,630,796	\$ 114,459		\$ 114,459	\$	\$ 2,125,284	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:

7/1/08

Ending:

6/30/09

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	\$ 461,247	\$ 53,401	\$ 53,401	\$	various	\$ 292,090	71
72	Current Year Purchases	124,539	8,738	8,738		various	9,856	72
73	Fully Depreciated Assets	428,842				various	428,842	73
74	Home Office Allocation	156,834	11,485	11,485			23,247	74
75	TOTALS	\$ 1,171,462	\$ 73,624	\$ 73,624	\$		\$ 754,035	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			18,165	1,330	1,330			8,094	77
78										78
79										79
80	TOTALS			\$ 61,665	\$ 1,330	\$ 1,330	\$		\$ 51,594	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)	\$ 4,884,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,413	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,413	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)	\$ 2,930,913	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	\$ 95,951	\$ 2,284	\$ 81,648	86
87	Congregate	446,267	11,079	291,177	87
88	Land	40,694			88
89					89
90					90
91	TOTALS	\$ 582,912	\$ 13,363	\$ 372,825	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 4,639	92
93			93
94			94
95		\$ 4,639	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

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: \$ 17,373 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

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>Not allowed to train CNAs due to survey tag received.</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$	2,341	\$ 154,760	\$	2,341	\$ 154,760	1
2	Licensed Speech and Language Development Therapist		hrs		961	75,253		961	75,253	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,936	252,733		3,936	252,733	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			\$	7,238	\$ 482,746	\$	7,238	\$ 482,746	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: 7/1/08

Ending: 6/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/09 (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	\$ 1,552,690	\$	1
2	Cash-Patient Deposits	29,870		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,091)	567,443		3
4	Supply Inventory (priced at)	22,582		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,465		7
8	Accounts Receivable (owners or related parties)	2,191		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,186,241	\$	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	3,947,453		14
15	Leasehold Improvements, at Historical Cost	157,731		15
16	Equipment, at Historical Cost	1,078,248		16
17	Accumulated Depreciation (book methods)	(3,192,771)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,406,802		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,438,157	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,624,398	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 119,613	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,870		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	376,246		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54		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	39,736		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 565,519	\$	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	Due to Affiliate	6,244		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 260,024	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 825,543	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,798,855	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,624,398	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,361,936	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,361,936	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(563,081)	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)	\$ (563,081)	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)	\$ 4,798,855	24 *

* This must agree with page 17, line 47.

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6/30/09

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	\$ 5,830,133	1
2	Discounts and Allowances for all Levels	(1,259,515)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,570,618	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,140,913	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,140,913	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	23,027	13
14	Non-Patient Meals	1,768	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	41,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,245	19
20	Radiology and X-Ray	8,647	20
21	Other Medical Services	6,497	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 110,110	23
D. Non-Operating Revenue			
24	Contributions	112,456	24
25	Interest and Other Investment Income***	37,639	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 150,095	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apartment/Duplex</u>	150,026	28
28a	<u>Gains/Losses on Investments and Misc Income</u>	(98,057)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 51,969	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,023,705	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,150,021	31
32	Health Care	3,411,209	32
33	General Administration	1,611,977	33
B. Capital Expense			
34	Ownership	204,878	34
C. Ancillary Expense			
35	Special Cost Centers	149,023	35
36	Provider Participation Fee	59,678	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,586,786	40
41	Income before Income Taxes (line 30 minus line 40)**	(563,081)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (563,081)	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.

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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	1,863	2,231	\$ 91,875	\$ 41.18	1
2	Assistant Director of Nursing	4,524	4,532	151,305	33.39	2
3	Registered Nurses	5,329	6,584	226,710	34.43	3
4	Licensed Practical Nurses	29,661	33,729	654,561	19.41	4
5	CNAs & Orderlies	80,165	88,792	917,482	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,896	4,311	53,510	12.41	8
9	Activity Director	1,833	2,027	21,255	10.49	9
10	Activity Assistants	6,645	7,193	62,344	8.67	10
11	Social Service Workers	3,318	3,701	61,585	16.64	11
12	Dietician	1,251	1,298	42,971	33.11	12
13	Food Service Supervisor	1,854	1,979	43,820	22.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,156	21,699	207,434	9.56	15
16	Dishwashers					16
17	Maintenance Workers	3,768	4,157	52,844	12.71	17
18	Housekeepers	16,441	18,888	175,562	9.29	18
19	Laundry					19
20	Administrator	3,533	3,883	212,002	54.60	20
21	Assistant Administrator					21
22	Other Administrative	1,515	1,620	34,227	21.13	22
23	Office Manager	1,699	1,975	49,177	24.90	23
24	Clerical	3,637	4,202	58,368	13.89	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: Ward Clerk, Resid	4,818	5,199	84,207	16.20	32
33	Other(specify) Community Nurse	11,807	13,114	245,391	18.71	33
34	TOTAL (lines 1 - 33)	205,713	231,114	\$ 3,446,630 *	\$ 14.91	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	96	\$ 4,887	3.1.3	35
36	Medical Director	132	12,000	3.9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	48	2,519	3.10.3	38
39	Pharmacist Consultant	174	3,130	3.10.3	39
40	Physical Therapy Consultant	12	740	3.10.3	40
41	Occupational Therapy Consultant	12	775	3.10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	596	3.10.3	43
44	Activity Consultant				44
45	Social Service Consultant	85	5,776	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	567	\$ 30,423		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	301	\$ 12,122	3.10.3	50
51	Licensed Practical Nurses	782	31,581	3.10.3	51
52	Certified Nurse Assistants/Aides	2,441	58,192	3.10.3	52
53	TOTAL (lines 50 - 52)	3,524	\$ 101,895		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debra Porter	Administrator	0	\$ 95,797	Workers' Compensation Insurance	\$ 57,723	IDPH License Fee	\$	
Bob Vincent	Executive Director	0	116,205	Unemployment Compensation Insurance	12,589	Advertising: Employee Recruitment	29,160	
				FICA Taxes	248,169	Health Care Worker Background Check		
				Employee Health Insurance	174,200	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		License	14,831	
						Dues	6,357	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Expense	23,011	Subscriptions	4,650	
(List each licensed administrator separately.)			\$ 212,002	Executive Retension	1,297	Other	60	
B. Administrative - Other				Home Office Allocation	25,878	Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fee Expense			\$ 360,156			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 360,156	TOTAL (agree to Schedule V, line 22, col.8)	\$ 542,867	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 55,058	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
My Inner View	Resident & Employee Surve		\$ 988				Out-of-State Travel	\$
Davis & Campbell	Attorney		120					
Polsinelli, Shalton, Flanigan	Attorney		1,485				In-State Travel	14,140
							Seminar Expense	5,417
							Home Office Allocation	11,894
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,593				TOTAL	\$ 31,451

* Attach copy of IMRF notifications

**See instructions.

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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 - \$5,103
- (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. \$ 21,030 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. \$ 59,678
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,768
- (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
- (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.