

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 N/A

	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	22,184	9,093	4,529	35,806	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,184	9,093	4,529	35,806	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.00%

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)

Meals, Lawn Care, Maintenance for AL & IL resident

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 Y NO Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES X NO

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

Date started 12/01/2013

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

YES X Date 12/01/2013 NO

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

YES X NO If YES, enter number of beds certified 109 and days of care provided 3,307

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Pleasant Meadows Senior Lvg

0052555

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	235,052	18,301	8,938	262,291		262,291		262,291		1
2	Food Purchase		247,965		247,965		247,965	(3,570)	244,395		2
3	Housekeeping	144,911	18,857		163,768		163,768		163,768		3
4	Laundry	41,457	1,575	5,796	48,828		48,828		48,828		4
5	Heat and Other Utilities			151,879	151,879		151,879	(3,230)	148,649		5
6	Maintenance	56,476	14,744	152,871	224,091		224,091	(33,648)	190,443		6
7	Other (specify):*										7
8	TOTAL General Services	477,896	301,442	319,484	1,098,822		1,098,822	(40,448)	1,058,374		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,010,002	209,848	2,720	2,222,570		2,222,570		2,222,570		10
10a	Therapy	3,352		684,252	687,604		687,604		687,604		10a
11	Activities	167,071	14,577	4,885	186,533		186,533	(964)	185,569		11
12	Social Services	42,855		19,049	61,904		61,904		61,904		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,223,280	224,425	722,906	3,170,611		3,170,611	(964)	3,169,647		16
	C. General Administration										
17	Administrative	180,553		347,900	528,453		528,453	(347,900)	180,553		17
18	Directors Fees										18
19	Professional Services			95,497	95,497		95,497	750	96,247		19
20	Dues, Fees, Subscriptions & Promotions			15,096	15,096		15,096		15,096		20
21	Clerical & General Office Expenses	108,082	27,813	43,892	179,787		179,787	(7,573)	172,214		21
22	Employee Benefits & Payroll Taxes			530,654	530,654		530,654		530,654		22
23	Inservice Training & Education			363	363		363		363		23
24	Travel and Seminar			986	986		986		986		24
25	Other Admin. Staff Transportation			33,068	33,068		33,068	(16,692)	16,376		25
26	Insurance-Prop.Liab.Malpractice			109,707	109,707		109,707		109,707		26
27	Other (specify):*										27
28	TOTAL General Administration	288,635	27,813	1,177,163	1,493,611		1,493,611	(371,415)	1,122,196		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,989,811	553,680	2,219,553	5,763,044		5,763,044	(412,827)	5,350,217		29

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

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

Facility Name & ID Number

Pleasant Meadows Senior Lvg

#0052555

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			6,716	6,716		6,716	159,720	166,436			30
31	Amortization of Pre-Op. & Org.			1,880	1,880		1,880		1,880			31
32	Interest			41,075	41,075		41,075	134,928	176,003			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			395,059	395,059		395,059	(395,059)				34
35	Rent-Equipment & Vehicles			5,551	5,551		5,551		5,551			35
36	Other (specify):*											36
37	TOTAL Ownership			450,281	450,281		450,281	(100,411)	349,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		167,428		167,428		167,428		167,428			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			283,308	283,308		283,308		283,308			42
43	Other (specify):* Non-Allowable Co			207,065	207,065		207,065	(207,065)				43
44	TOTAL Special Cost Centers		167,428	490,373	657,801		657,801	(207,065)	450,736			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,989,811	721,108	3,160,207	6,871,126		6,871,126	(720,303)	6,150,823			45

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

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,570)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,365	30		9
10	Interest and Other Investment Income	(25)	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	(363)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(174,731)	43		24
25	Fund Raising, Advertising and Promotional	(18,802)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(111,477)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (305,603)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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)	(414,700)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (414,700)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (720,303)		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			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Pleasant Meadows Senior Lvg

ID# 0052555

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

Pleasant Meadows Senior Lvg

0052555

12/31/2014

Schedule 5A

Schedule 5A

VI. ADJUSTMENT DETAIL

NON-ALLOWABLE EXPENSES

LINE 29 - Other

Description	Amount	Schedule V Reference
To offset Other Income against Office Expenses	(7,297)	21
To disallow X-Ray expense	(8,312)	43
To disallow Lab expense	(4,857)	43
To disallow non-allowable auto expense	(16,692)	25
To disallow IL Activity Supplies	(964)	11
To disallow IL Utilities expense	(3,230)	5
To disallow IL Phone expense	(276)	21
To disallow IL Depreciation expense	(36,201)	30
To capitalize Painting Cost for Medicaid Cost Report	<u>(33,648)</u>	6
Total	<u><u>(111,477)</u></u>	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	(3,570)	0	0	0	0	0	0	0	0	0	0	(3,570)	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,570)	0	0	0	0	0	0	0	0	0	0	(3,570)	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	(347,900)	0	0	0	0	0	0	0	0	0	(347,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	750	0	0	0	0	0	0	0	0	0	750	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	(347,150)	0	(347,150)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,570)	(347,150)	0	(350,720)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	3,365	192,556	0	0	0	0	0	0	0	0	0	195,921	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	134,953	0	0	0	0	0	0	0	0	0	134,928	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(395,059)	0	0	0	0	0	0	0	0	0	(395,059)	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	3,340	(67,550)	0	(64,210)	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):*	(193,896)	0	0	0	0	0	0	0	0	0	0	(193,896)	43
44	TOTAL Special Cost Centers	(193,896)	0	0	0	0	0	0	0	0	0	0	(193,896)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(194,126)	(414,700)	0	(608,826)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PMOP, LLC	47.5			Pleasant Meadows		
Nachum Langsner	23.75			Property, LLC	Evanston, IL	Lessor
Miriam Langsner	23.75			Sheridan Healthcare		
AL Truhlar	2.5			Services	Evanston, IL	Management Co.
Susan Truhlar	2.5					

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	17	Administrative -Other	\$ 347,900	Sheridan Healthcare Services	0.00%	\$	\$ (347,900)	1
2	V								2
3	V	34	Rent	395,059	Pleasant Meadows Property, LLC	100.00%		(395,059)	3
4	V	19	Professional Services		Pleasant Meadows Property, LLC	100.00%	750	750	4
5	V	30	Depreciation		Pleasant Meadows Property, LLC	100.00%	192,556	192,556	5
6	V	32	Interest Expense		Pleasant Meadows Property, LLC	100.00%	125,245	125,245	6
7	V	32	Loan Cost Amortz.		Pleasant Meadows Property, LLC	100.00%	9,708	9,708	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 742,959			\$ 328,259	\$ *	(414,700)	14

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

Facility Name & ID Number Pleasant Meadows Senior Lvg # 0052555 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	David Langsner	N/A	N/A	N/A	0	0	0.00	Accounting	\$ 17,000	L 19, Col 3	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	\$ 17,000		13

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

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

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3		N/A							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

Pleasant Meadows Senior Lvg

0052555

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Name of Lender	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		Bank Leumi USA		X	Mortgage		12/1/2013	\$ 2,325,000	\$ 2,208,750			\$ 125,245	1						
2													2						
3													3						
4		Laon Amortization			Laon Cost		12/1/2013					9,708	4						
5				X									5						
		Working Capital																	
6		Bank Leumi USA		X	Line of Credit		12/2/2013	1,000,000	848,350	12/4/2015		33,783	6						
7													7						
8		Laon Amortization		x								7,292	8						
9		TOTAL Facility Related						\$ 3,325,000	\$ 3,057,100			\$ 176,028	9						
		B. Non-Facility Related*																	
10										Interest income offset		(25)	10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			(25)	14						
15		TOTALS (line 9+line14)						\$ 3,325,000	\$ 3,057,100			\$ 176,003	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>N/A</u>			8
	2010				9
	2011				10
	2012				11
	2013				12
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2013	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pleasant Meadows Senior Lvg COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0052555

CONTACT PERSON REGARDING THIS REPORT Mr. Langsner

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	N/A	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,356 B. General Construction Type: Exterior Brick Frame Wood & stell 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).
14 units Duplex/Independent Living Facility 3, 808 residents days

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: 9,400 2. Number of Years Over Which it is Being Amortized: 5 yrs.
 3. Current Period Amortization: 1,880 4. Dates Incurred: 12/01/2013

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

XI. OWNERSHIP COSTS:

A. Land.		1	2	3	4	
		Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>46,356</u>	<u>2013</u>	<u>\$ 254,254</u>	1
2						2
3	TOTALS		<u>46,356</u>		<u>\$ 254,254</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		2013	1976	\$ 1,525,523	\$	27.5	\$ 55,474	\$ 55,474	\$ 57,786
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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	2014	\$ 33,648	\$	5yrs	\$ 3,365	\$ 3,365	\$ 3,365	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,559,171	\$		\$ 58,839	\$ 58,839	\$ 61,151	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 8,050	\$ 2,683	\$ 2,683	\$	3 yrs	\$ 2,817	71
72	Current Year Purchases	43,356	4,033	4,033		5 yrs	4,033	72
73	Fully Depreciated Assets							73
74	Building CO.	504,407		100,881	100,881	5 yrs	151,322	74
75	TOTALS	\$ 555,813	\$ 6,716	\$ 107,597	\$ 100,881		\$ 158,172	75

D. Vehicle Costs. (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				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,369,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,716	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 166,436	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 159,720	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 219,323	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	Land AL 2013	\$ 58,867	\$	\$	86
87	Building AL 2013	353,200	12,844	13,379	87
88	Furniture & Equipment AL 2013	116,784	23,357	35,035	88
89					89
90					90
91	TOTALS	\$ 528,851	\$ 36,201	\$ 48,414	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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:				\$			3
4	Additions							4
5		<u>N/A</u>						5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,551 Description: \$1,675 Copier, \$3,816 Medical Equipment, \$60 Postage Meter

(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	<u>N/A</u>				19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Pleasant Meadows Senior Lvg # 0052555 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
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?</p> <p><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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L 10a, Col 3	hrs	\$	2,125	\$ 138,156	\$	2,125	\$ 138,156	1	
2	Licensed Speech and Language Development Therapist	L 10a, Col 3	hrs		311	20,213		311	20,213	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	L 10a, Col 3	hrs		8,086	525,583		8,086	525,583	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	L 39, Col 2	# of prescrpts				167,428		167,428	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Resptory Therapy</u>	L 10a, Col 1	121	3,352	6	300		127	3,652	13	
14	TOTAL			\$ 3,352	10,528	\$ 684,252	\$ 167,428	10,649	\$ 855,032	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 Senior Lvg

0052555

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(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	\$ 2,379	\$ 2,379	1
2	Cash-Patient Deposits	100	100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,218)	1,702,561	1,702,561	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	207,807	207,807	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,912,847	\$ 1,912,847	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		254,254	13
14	Buildings, at Historical Cost		1,525,523	14
15	Leasehold Improvements, at Historical Cost		33,648	15
16	Equipment, at Historical Cost	51,406	555,813	16
17	Accumulated Depreciation (book methods)	(6,850)	(219,323)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	9,400	9,400	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,037)	(2,037)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		480,437	22
23	Other(specify): <u>Financing Fees</u>	4,583	40,709	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 56,502	\$ 2,678,424	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,969,349	\$ 4,591,271	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 566,924	\$ 566,924	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	848,350	848,350	29
30	Accrued Salaries Payable	257,661	257,661	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,726	11,726	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,258	12,225	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17 C</u>	198,671	198,671	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,885,590	\$ 1,895,557	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,208,750	40
41	Bonds Payable			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)	\$	\$ 2,208,750	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,885,590	\$ 4,104,307	46
47	TOTAL EQUITY(page 18, line 24)	\$ 83,759	\$ 486,964	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,969,349	\$ 4,591,271	48

*(See instructions.)

Pleasant Meadows Senior Lvg
0052555
12/31/2014

Schedule 17C

XV. Balance Sheet

C. Current Liabilities	Operating	After Consolidation
Line 36 -Other Current Liabilities		
Due Prior Owners	3,261	3,261
Accrued Expense	87,708	87,708
Due to Othr Related Parties	1,582	1,582
Accrued Assessment Tax	106,120	106,120
	198,671	198,671

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (40,242)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (40,242)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	124,001	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)	\$ 124,001	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)	\$ 83,759	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant Meadows Senior Lvg# 0052555Report Period Beginning: 01/01/2014Ending: 12/31/2014

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,067,486	1
2	Discounts and Allowances for all Levels	(708,325)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,359,161	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,304,845	6
7	Oxygen	9,574	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,314,419	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		13
14	Non-Patient Meals	3,570	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	158,014	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,709	19
20	Radiology and X-Ray	8,817	20
21	Other Medical Services	15,902	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 192,012	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beauty Shop and Other Income	8,917	28
28a	Independent Living	120,593	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 129,510	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,995,127	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,098,822	31
32	Health Care	3,170,611	32
33	General Administration	1,493,611	33
B. Capital Expense			
34	Ownership	450,281	34
C. Ancillary Expense			
35	Special Cost Centers	374,493	35
36	Provider Participation Fee	283,308	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,871,126	40
41	Income before Income Taxes (line 30 minus line 40)**	124,001	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 124,001	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,972,078	44
45	Private Pay - Net Inpatient Revenue	1,453,621	45
46	Medicare - Net Inpatient Revenue	684,571	46
47	Other-(specify) <u>Managed Care</u>	248,891	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,359,161	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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	1,877	2,065	\$ 80,124	\$ 38.80	1
2	Assistant Director of Nursing	1,736	2,010	61,064	30.38	2
3	Registered Nurses	15,773	16,820	390,028	23.19	3
4	Licensed Practical Nurses	20,009	21,351	437,677	20.50	4
5	CNAs & Orderlies	71,223	75,153	803,157	10.69	5
6	CNA Trainees					6
7	Licensed Therapist	110	121	3,352	27.70	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,829	2,042	24,306	11.90	9
10	Activity Assistants	6,654	7,202	66,457	9.23	10
11	Social Service Workers	2,340	2,568	42,855	16.69	11
12	Dietician					12
13	Food Service Supervisor	1,934	2,084	45,976	22.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,556	4,069	59,606	14.65	15
16	Dishwashers	13,558	14,524	129,470	8.91	16
17	Maintenance Workers	2,998	3,129	56,476	18.05	17
18	Housekeepers	10,388	11,276	112,225	9.95	18
19	Laundry	4,050	4,423	41,457	9.37	19
20	Administrator	1,877	2,055	115,822	56.36	20
21	Assistant Administrator	2,031	2,675	64,731	24.20	21
22	Other Administrative					22
23	Office Manager	2,706	2,332	31,585	13.54	23
24	Clerical	3,425	3,978	76,497	19.23	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	1,860	2,042	24,649	12.07	31
32	Other Health C: See Sch 20A	12,733	13,731	289,611	21.09	32
33	Other(specify) See Sch 20A	1,879	2,058	32,686	15.88	33
34	TOTAL (lines 1 - 33)	184,546	197,708	\$ 2,989,811 *	\$ 15.12	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	170	\$ 8,938	1(3)	35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant			10(3)	37
38	Nurse Consultant			10(3)	38
39	Pharmacist Consultant	# of Resident	2,720	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	68	4,885	11(3)	44
45	Social Service Consultant	8	579	12(3)	45
46	Other(specify) <u>Chaplain</u>	Monthly	18,470	12(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	246	\$ 47,592		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Schedule 20 A

XXVIII. A. Staffing and Salary costs

Name	Number of Hrs Worked	Number Hrs Paid	Tot Sal & Wages	Ave. Hourly
Nurse Supervisor	708	756	18,347	24.27
MDS Coordinator	2,055	2,262	71,793	31.74
RN /LPN Inservice Director	114	119	2,501	21.02
Rehabilitation Nursing Wages	1,993	2,169	67,272	31.02
Rehabilitation Aides Wages	3,593	3,836	53,390	13.92
Alzheimer Supervisor	1,865	2,043	45,462	22.25
Drives	2,405	2,546	30,846	12.12
Total	12,733	13,731	289,611	21.09

Name	Number of Hrs Worked	Number Hrs Paid	Tot Sal & Wages	Ave. Hourly
Plant Operation Manager	1,879	2,058	32,686	15.88
Total	1,879	2,058	32,686	15.88

Pleasant Meadows Senior Lvg
Provider #: 0052555
01/01/2014 to 12/31/2014

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

RK Dixon	Email Services	48
Personal Planners, Inc	Unemployment Consultant	1,345
David Langsner	Accounting Services	17,000
Frost Ruttenberg & Rothblatt	Accounting Services	12,875
Total for Schedule 21A		<u>31,268</u>
Total Per Schedule 3 Line 19 Column 3		95,497
From Building Company		750
To disallow non-allowable Prof Fees -Other		0
Total Per Schedule 3 Line 19 Column 8		96,247

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3										N/A		
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Pleasant Meadows Senior Lvg

0052555

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? No
If YES, give association name and amount. N/A
- (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? N/A
- (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? N/A
- (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 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,313 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 283,308
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,570
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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? Yes
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.