

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014 Report Period Beginning: 0701/14 Ending: 06/30/15

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	98	Skilled (SNF)	98	35,770	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	98	TOTALS	98	35,770	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	14,830	15,111	1,843	31,784	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,830	15,111	1,843	31,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.86%

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

0 (Do not include bed-hold days in Section B.)

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

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

N/A

F. Does the facility maintain a daily midnight census?

YES

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

YES NO

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

YES NO

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

Date started 03/01/1976

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 98 and days of care provided 1,843

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	234,765	16,878	9,021	260,664		260,664	260,664		1	
2	Food Purchase		214,368		214,368		214,368	(336)	214,032	2	
3	Housekeeping	97,294	19,098		116,392		116,392		116,392	3	
4	Laundry	66,777	8,569	3,213	78,559		78,559		78,559	4	
5	Heat and Other Utilities			116,019	116,019	(2,615)	113,404		113,404	5	
6	Maintenance	80,061	4,059	15,391	99,511		99,511	(8,287)	91,224	6	
7	Other (specify):*									7	
8	TOTAL General Services	478,897	262,972	143,644	885,513	(2,615)	882,898	(8,623)	874,275	8	
	B. Health Care and Programs										
9	Medical Director			15,142	15,142		15,142		15,142	9	
10	Nursing and Medical Records	1,591,142	69,211	173,944	1,834,297		1,834,297		1,834,297	10	
10a	Therapy	63,462		377,591	441,053		441,053		441,053	10a	
11	Activities	70,974	6,712	3,808	81,494		81,494		81,494	11	
12	Social Services	31,928			31,928		31,928		31,928	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* CHAPLAIN	32,574	166		32,740		32,740		32,740	15	
16	TOTAL Health Care and Programs	1,790,080	76,089	570,485	2,436,654		2,436,654		2,436,654	16	
	C. General Administration										
17	Administrative	177,151			177,151		177,151	(14,233)	162,918	17	
18	Directors Fees									18	
19	Professional Services			84,864	84,864		84,864		84,864	19	
20	Dues, Fees, Subscriptions & Promotions			54,635	54,635		54,635	(27,229)	27,406	20	
21	Clerical & General Office Expenses	74,062	17,498	16,573	108,133		108,133	(12,257)	95,876	21	
22	Employee Benefits & Payroll Taxes			323,738	323,738		323,738		323,738	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			11,003	11,003		11,003		11,003	24	
25	Other Admin. Staff Transportation			1,936	1,936		1,936		1,936	25	
26	Insurance-Prop.Liab.Malpractice			113,270	113,270		113,270		113,270	26	
27	Other (specify):*	85,235			85,235		85,235		85,235	27	
28	TOTAL General Administration	336,448	17,498	606,019	959,965		959,965	(53,719)	906,246	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,605,425	356,559	1,320,148	4,282,132	(2,615)	4,279,517	(62,342)	4,217,175	29	

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			91,334	91,334		91,334		91,334			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,697	6,697		6,697	(6,402)	295			32
33	Real Estate Taxes			52,924	52,924		52,924		52,924			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,528	3,528		3,528		3,528			35
36	Other (specify):*											36
37	TOTAL Ownership			154,483	154,483		154,483	(6,402)	148,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					2,615	2,615		2,615			40
41	Coffee and Gift Shops			11,592	11,592		11,592		11,592			41
42	Provider Participation Fee			235,423	235,423		235,423		235,423			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			247,015	247,015	2,615	249,630		249,630			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,605,425	356,559	1,721,646	4,683,630		4,683,630	(68,744)	4,614,886			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning: 0701/14

Ending: 06/30/15

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	(336)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,855)	21		5
6	Rented Facility Space	(1,700)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,402)	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	(662)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,691)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,538)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,184)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(28,560)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,560)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (68,744)		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		2,615	5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 2,615		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY					
48		49		50	51
					52

PLEASANT HILL VILLAGE

ID# 0021014

Report Period Beginning: 0701/14

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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	(336)	0	0	0	0	0	0	0	0	0	0	(336)	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	(8,287)	0	0	0	0	0	0	0	0	0	(8,287)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(336)	(8,287)	0	(8,623)	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	(14,233)	0	0	0	0	0	0	0	0	0	(14,233)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(27,229)	0	0	0	0	0	0	0	0	0	0	(27,229)	20
21	Clerical & General Office Expenses	(6,217)	(6,040)	0	0	0	0	0	0	0	0	0	(12,257)	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	(33,446)	(20,273)	0	(53,719)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,782)	(28,560)	0	(62,342)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,402)	0	0	0	0	0	0	0	0	0	0	(6,402)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,402)	0	0	0	0	0	0	0	0	0	0	(6,402)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(40,184)	(28,560)	0	(68,744)	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
N/A	N/A	N/A		PLEASANT HILL RESIDENCE	GIRARD	INDEPENDENT & ASSISTED LIVING FACILITY

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 ADMINISTRATIVE WAGES	\$			\$	(14,233)	1
2	V	6 MAINTENANCE WAGES					(8,287)	2
3	V	21 OFFICE SPACE RENT					(6,040)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	* (28,560)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

PLEASANT HILL VILLAGE

0021014

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0701/14

Ending:

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A							\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

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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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	FIRST NAT'L BK OF RAYMOND	X		OPERATING CAPITAL		11/24/14	400,075	100,075	11/30/15	0.0450	6,177						
7	VARIOUS VENDORS		X								520						
8																	
9	TOTAL Facility Related						\$ 400,075	\$ 100,075			\$ 6,697						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 400,075	\$ 100,075			\$ 6,697						

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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 2014 report.		\$	25,692		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.)		\$	52,411		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	26,719		3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	26,205		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.		\$	52,924		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	44,614	10			
	2013	51,385	11			
	2014	52,411	12			
REAL ESTATE TAX ACCRUED @ 6/30/15 WAS FIGURED FOR JANUARY - JUNE 2015 USING THE 2014 TAX BILL 52411/12*6=26205				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 X 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014 Report Period Beginning:

0701/14 Ending:

06/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000 B. General Construction Type: Exterior BRICK Frame STEEL & FIRE RESI Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 29,505 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: 1973-1976

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	98	1976	1976	\$ 975,998	\$ 24,400	40	\$ 24,400	\$	\$ 959,731
5									
6									
7									
8									
Improvement Type**									
9	LANDSCAPING, PA SYSTEM PHV SIGN DIRECTORY BOARD		1976	5,916					
10	DIRECTORY BOARD LETTERS, PATIO CEMENT, LANDSCAPING		1977	1,273					
11	LANDSCAPING, AIR CONDITIONER, FLAG PLE LIGHT		1978	6,194					
12	LANDSCAPING, FENCE, CABINETS, INTERCOM, & MIKE MIXER		1980	3,688					
13	REMODELING		1981	485					
14	ENERGY CONTROL SYSTEM, REMODELING		1982	19,060					
15	CABINETS		1983	271					
16	CABINET TOP		1984	408					
17	GARAGE SHOP, STORAGE BLDG, REMODELING, DRIVEWAY		1985	74,072	38,414	VARIOUS	38,414		798,799
18	REMODELING		1986	5,469					
19	BACKFLOW PREVENTOR, WINDOW, & MIXING VALVE		1989	8,180					
20	FIRE ALARM		1991	1,298					
21	NEW ROOF, STORM WINDOWS, PAVILION		1992	61,405					
22	LANDSCAPING		1993	1,240					
23	LANDSCAPING, ROOF		1994	43,344					
24	NEW ROOF, REMODELING, AIR CONDITIONERS		1994	32,226					
25	SECURITY SYSTEM, REMODELING		1994	6,907					
26	ARCHITECH, REMODELING, A/C, CARPET, FLOOR, PAINT & PAP		1995	40,250					
27	DRIVEWAY, ARCHITECH, LANDSCAPING, A/C WINDOW TREATM		1995	28,013					
28	ROOF, WATERLINE, COVEBASE, & HAND RAIL		1996	40,657					
29	LANDSCAPING		1997	915					
30	ROOF TOP AIR CONDITIONER		1997	6,795					
31	PAINT & WALL PAPER		1997	24,720					
32	FLOORING		1997	12,182					
33	COVEBASE		1997	2,713					
34	REPLACE CEILING		1997	16,220					
35	EXHAUST FAN		1997	428					
36	WATER HYDRANT		1997	527					

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PARKING AREA	1998	\$ 17,920	\$		\$	\$	\$	37
38	LANDSCAPING	1998	715						38
39	ARCHITECH FEES	1998	8,912						39
40	PAINT & WALL PAPER	1998	4,691						40
41	FLOORING	1998	428						41
42	WALL TREATMENTS & PICTURES	1998	442						42
43	WINDOWS	1998	2,123						43
44	OUTDOOR LIGHTING	1998	2,761						44
45	FIRE ALARM SYSTEM	1998	3,218						45
46	HEATING & COOLING SYSTEM	1998	1,824						46
47	LANDSCAPING	1999	1,439						47
48	DEMENTIA WING	1999	287,249						48
49	DEMENTIA WING ELECTRICAL	1999	589						49
50	DEMENTIA WING SURVEY	1999	3,250						50
51	PAINT & WALL PAPER	1999	4,025						51
52	WINDOW TREATMENT	1999	526						52
53	CARPET	1999	2,531						53
54	HEATING & COOLING SYSTEM	1999	4,384						54
55	ROOF TOP AIR CONDITIONER	1999	6,940						55
56	LANDSCAPING	2000	1,600						56
57	DEMENTIA WING	2000	19,566						57
58	SURVEY INDEPENDENT LIVING CENTER	2000	1,875						58
59	SECURITY DOOR ALARM	2000	1,415						59
60	HOT WATER HEATING SYSTEM	2000	26,436						60
61	CARPET	2000	4,462						61
62	VINAL SLIDING DOOR	2000	2,359						62
63	HEATING & COOLING SYSTEM	2000	6,368						63
64	LANDSCAPING	2001	1,600						64
65	ELECTRICAL WORK	2001	850						65
66	MASTER PLAN	2001	10,000						66
67	NEW LAUNDRY ROOM WALL	2001	497						67
68	DUCT WORK	2001	344						68
69	WATER LINE	2001	60,000						69
70	TOTAL (lines 4 thru 69)		\$ 1,912,193	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,912,193	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	1
2	SLIDER WINDOWS	2001	2,469						2
3	FLOORING	2001	2,364						3
4	PAINT	2001	475						4
5	FIRE ALARM SYSTEM	2001	3,317						5
6	INTERIOR DECORATING	2001	1,863						6
7	ELECTRIC HEAT UNITS	2001	7,940						7
8	DRIVEWAY	2002	21,209						8
9	SIDEWALK	2002	960						9
10	DOORS	2002	2,515						10
11	AC CONDENSER	2002	1,572						11
12	WINDOWS	2002	266						12
13	EXHAUST FAN	2002	1,802						13
14	COUNTER TOP & WALL REPAIR	2002	604						14
15	ELECTRICAL GROUNDING	2002	2,581						15
16	POLE LIGHT	2002	3,337						16
17	ELECTRIC HEAT	2002	704						17
18	ENTRYWAY CULVERT	2003	2,600						18
19	700' 6" TILE	2003	1,561						19
20	CONCRETE WASHER BASE	2003	750						20
21	PERGOLA	2003	2,800						21
22	MASTER PLAN DEVELOPMENT	2003	892						22
23	HEATER	2003	1,064						23
24	SIGN LIGHTING	2003	2,529						24
25	CARPET	2003	378						25
26	LANDSCAPING	2004	4,748						26
27	ELECTRICAL WORK	2004	1,025						27
28	SECURITY DOOR ALARM	2004	812						28
29	GENERATOR & TRANSFER SWITHC	2004	9,151						29
30	LAUNDRY ROOM A.C.	2004	11,320						30
31	RETAINING WALL GAZEBO AREA	2005	7,254						31
32	ALUMINUM DOORS	2005	2,700						32
33	GAZEBO	2005	7,778						33
34	TOTAL (lines 1 thru 33)		\$ 2,023,533	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,023,533	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	1
2	WINDOW TREATMENT	2005	868						2
3	HEAT & COOL SYSTEM	2005	566						3
4	FIRE SAFETY SYSTEM	2005	1,041						4
5	SIDEWALK	2006	5,230						5
6	GAZEBO	2005	3,139						6
7	PAVILLION	2006	576						7
8	OUTSIDE EMERGENCY LIGHTING	2005	1,081						8
9	NEW SOFFIT, FASCIA, GUTTERING	2007	1,352						9
10	SIDEWALK	2008	3,774						10
11	TRANE 5 TON 3 PH ROOFTOP UNIT	2007	5,078						11
12	WINDOW TREATMENT	2007	2,923						12
13	MDM HEAT-COOL	2008	555						13
14	BATHROOM FIXTURES	2008	2,658						14
15	CARPET & COVEBASE	2008	758						15
16	OUTSIDE LIGHTING	2008	371						16
17	REMOTE ANNUNCIATOR FOR EMERGENCY GENERATOR	2008	4,097						17
18	HEADS FOR POSTS LIFE SAFETY CODE	2008	354						18
19	REPLACE SHINGLES ON 2 WINGS	2008	3,144						19
20	HEAT & COOL SYSTEM	2008	564						20
21	WINDOW TREATMENT	2008	4,024						21
22	PLUMBING TO CODE	2008	9,702						22
23	CEILING TILE	2008	582						23
24	ELECTRICAL WORK	2008	2,830						24
25	BATHROOM FIXTURES	2009	725						25
26	RAILING BETWEEN BUILDINGS	2009	1,699						26
27	5 TON COMPRESSOR UNIT	2009	2,683						27
28	HEAT & COOL SYSTEM	2009	614						28
29	GAZEBO BRICK WALL	2009	5,073						29
30	ROOF VALLEY REPAIR	2009	1,585						30
31	RETEXTURE B HALLWAY CEILING	2009	2,382						31
32	FLAT ROOF REPLACEMENT	2010	45,160						32
33	ROOF REPLACEMENT	2010	63,178						33
34	TOTAL (lines 1 thru 33)		\$ 2,201,899	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

0701/14

Ending:

06/30/15

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,201,899	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	1
2	PANACEA WALL DEFENDER	2009	2,274						2
3	GENERATOR CIRCUITS	2009	1,434						3
4	FLOORING KITCHEN & BREAKROOM	2010	1,300						4
5	MDM HEAT COOL	2010	1,064						5
6	LOWER MIXING VALVUE	2010	719						6
7	BACK DOOR	2010	2,800						7
8	SLAB FOR WASHER	2010	1,367						8
9	SPRINKLER HEADS	2010	504						9
10	WINDOW TREATMENTS	2010	591						10
11	CONCRETE PAD	2011	2,130						11
12	ELECTRICAL WIRING GENERATOR TRANSFER SWITCH	2011	11,115						12
13	ELECTRICAL WIRING MAIN BREAKER	2011	1,131						13
14	NEW WINDOWS COMMON AREA	2011	3,743						14
15	LANDSCAPE MEMORIAL AREA & GAZEBO	2011	1,515						15
16	DOOR BY KITCHEN	2011	1,252						16
17	COMMON AREA WINDOWS	2011	1,247						17
18	3" PUMP INSTALLATION	2011	9,318						18
19	2000 LIFE SAFTEY CODE IMPROVEMENTS	2011	7,540						19
20	MDM HEAT COOL UNITS FOR ROOMS	2012	8,580						20
21	LAMINATE FLOORING	2012	2,222						21
22	CONCRETE DAM AT EDGE OF POND	2012	1,540						22
23	ELECTRICAL HOOKUPS	2012	5,809						23
24	BULLDOZING POND AREA	2013	12,420						24
25	SPRINKLER SYSTEM	2013	1,084						25
26	LIGHTING	2013	1,442						26
27	SPRINKLER SYSTEM	2013	18,976						27
28	WATER COOLER	2013	720						28
29	BRIDGE AND WALKING PATH	2013	3,016						29
30	INDIVIDUAL HEAT/COOL UNITS FOR ROOMS	2013	1,334						30
31	AC SYSTEM FOR FRONT OF BUILDING	2013	9,500						31
32	WASHER EXTRACTOR	2013	9,375						32
33	ROOF TOP AC UNIT FOR WING, COMMON & NURSE STATI	2013	9,549						33
34	TOTAL (lines 1 thru 33)		\$ 2,338,510	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,338,510	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	1
2	NEW CIRCUIT & GCFI BREAKERS	2014	4,834						2
3	PATIO & WALKING PATH AT FISH PIER	2014	3,633						3
4	PIER & DOCK	2015	3,209						4
5	LANDSCAPING IN FRONT OF NURSING HOME	2015	6,928						5
6	HEATING & AC UNIT	2014	667						6
7	5 TON TRANE UNIT & COMPRESSOR	2014	7,273						7
8	HEATING UNIT	2015	667						8
9	5 HEATING/COOLING UNITS	2015	5,031						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	TOTAL (lines 1 thru 33)		\$ 2,370,752	\$ 62,814		\$ 62,814	\$	\$ 1,758,530	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 179,942	\$ 24,663	\$ 24,663	\$	VARIOUS	\$ 82,802	71
72	Current Year Purchases	78,878	3,857	3,857		VARIOUS	3,857	72
73	Fully Depreciated Assets	640,233				VARIOUS	640,233	73
74								74
75	TOTALS	\$ 899,053	\$ 28,520	\$ 28,520	\$		\$ 726,892	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	RESIDENTIAL OUTINGS	BUSS	2003	\$ 57,588	\$	\$	\$	5	\$ 57,588	76
77										77
78										78
79										79
80	TOTALS			\$ 57,588	\$	\$	\$		\$ 57,588	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,355,893	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,334	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,334	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)	\$ 2,543,010	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 3,528 Description: OFFICE COPIER

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	L10A;C3	hrs	\$	8,234	\$ 171,872	\$	8,234	\$ 171,872	1	
2	Licensed Speech and Language Development Therapist	L10A;C3	hrs		1,518	42,672		1,518	42,672	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	L10A;C3	hrs		8,014	163,047		8,014	163,047	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	17,766	\$ 377,591	\$	17,766	\$ 377,591	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning: 0701/14

Ending:

06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,037,591	\$	1
2	Cash-Patient Deposits	407		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 286,113)	1,198,905		3
4	Supply Inventory (priced at COST)	7,090		4
5	Short-Term Investments			5
6	Prepaid Insurance	31,944		6
7	Other Prepaid Expenses	2,985		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,278,922	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	28,500		13
14	Buildings, at Historical Cost	2,218,855		14
15	Leasehold Improvements, at Historical Cost	152,404		15
16	Equipment, at Historical Cost	956,134		16
17	Accumulated Depreciation (book methods)	(2,543,010)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,505		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,763)		20
21	Restricted Funds	69,498		21
22	Other Long-Term Assets (spec CAPITAL CONTRIB	189,940		22
23	Other(specify): FARM LAND	60,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,148,063	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,426,985	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 381,282	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	407		28
29	Short-Term Notes Payable	100,075		29
30	Accrued Salaries Payable	97,128		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,616		32
33	Accrued Interest Payable	321		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 657,829	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 657,829	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,769,156	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,426,985	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,701,668	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,701,668	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	67,488	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)	\$ 67,488	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)	\$ 2,769,156	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 4,673,518	1
2	Discounts and Allowances for all Levels	(21,528)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,651,990	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	13,757	12
13	Barber and Beauty Care	2,615	13
14	Non-Patient Meals	336	14
15	Telephone, Television and Radio	3,855	15
16	Rental of Facility Space	1,700	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,263	23
D. Non-Operating Revenue			
24	Contributions	11,625	24
25	Interest and Other Investment Income***	6,402	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,027	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	REIMBURSEMENT 22,520; ENDOWMENT FD 1,762	24,282	28
28a	FUND RAISING	34,556	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 58,838	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,751,118	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	885,513	31
32	Health Care	2,436,654	32
33	General Administration	959,965	33
B. Capital Expense			
34	Ownership	154,483	34
C. Ancillary Expense			
35	Special Cost Centers	11,592	35
36	Provider Participation Fee	235,423	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,683,630	40
41	Income before Income Taxes (line 30 minus line 40)**	67,488	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 67,488	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,967,641	44
45	Private Pay - Net Inpatient Revenue	1,686,014	45
46	Medicare - Net Inpatient Revenue	1,019,863	46
47	Other-(specify) <u>CHARITABLE CARE</u>	(21,528)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,651,990	49

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

0021014

Report Period Beginning: **0701/14**

Ending:

06/30/15

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	1,830	2,070	\$ 79,415	\$ 38.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,835	5,008	124,771	24.91	3
4	Licensed Practical Nurses	22,063	24,002	490,029	20.42	4
5	CNAs & Orderlies	82,529	87,041	896,927	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,399	3,761	63,462	16.87	8
9	Activity Director	804	828	13,077	15.79	9
10	Activity Assistants	6,203	6,475	57,897	8.94	10
11	Social Service Workers	2,672	2,882	31,928	11.08	11
12	Dietician					12
13	Food Service Supervisor	2,340	2,451	45,936	18.74	13
14	Head Cook	5,985	6,501	72,102	11.09	14
15	Cook Helpers/Assistants	10,413	10,861	104,236	9.60	15
16	Dishwashers	1,334	1,577	12,491	7.92	16
17	Maintenance Workers	4,155	4,488	80,061	17.84	17
18	Housekeepers	9,794	10,406	97,294	9.35	18
19	Laundry	6,168	6,686	66,777	9.99	19
20	Administrator	3,760	4,188	177,151	42.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,753	4,167	74,062	17.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CHAPLAIN	1,815	1,908	32,574	17.07	32
33	Other(specify) DEVELOPMENT	3,332	3,580	85,235	23.81	33
34	TOTAL (lines 1 - 33)	177,184	188,880	\$ 2,605,425 *	\$ 13.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	169	\$ 9,021	L1;C3	35
36	Medical Director	108	15,142	L9;C3	36
37	Medical Records Consultant	16	414	L10;C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	139	6,970	L10;C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	3,080	L11;C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	487	\$ 34,627		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	616	21,546	L10;C3	51
52	Certified Nurse Assistants/Aides	2,111	43,804	L10;C3	52
53	TOTAL (lines 50 - 52)	2,727	\$ 65,350		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
PAULETTE BUCH-MILLER	EX DIRECTOR	0	\$ 85,507	Workers' Compensation Insurance	\$ 98,321	IDPH License Fee	\$ 1,990	
KAMI HOPPER	ADMINISTRATOR	0	91,644	Unemployment Compensation Insurance	3,381	Advertising: Employee Recruitment	9,520	
				FICA Taxes	196,484	Health Care Worker Background Check	649	
				Employee Health Insurance	8,583	(Indicate # of checks performed <u>33</u>)		
				Employee Meals		Patient Background Checks	34	
				Illinois Municipal Retirement Fund (IMRF)*		PUBLIC RELATIONS	21,691	
				EMPLOYEE PHYSICALS & IMUNIZATIONS	3,507	YELLOW PAGE ADVERTISING	5,538	
				EMPLOYEE UNIFORMS	1,853	DUES-ASSOCIATION	5,929	
				EMPLOYEE X-MAS & INCENTIVE	9,771	DUES OTHER	8,423	
				FLEX PLAN ADMINISTRATION	1,838	NEWSPAPERS & MAGAZINES	555	
						Less: Public Relations Expense	(21,691)	
						Non-allowable advertising	()	
						Yellow page advertising	(5,538)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 177,151	TOTAL (agree to Schedule V, line 22, col.8)	\$ 323,738	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 27,406	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	11,003
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
CPA FIRM	AUDIT		\$ 5,250				TOTAL	\$ 11,003
CPA FIRM	DATA PROCESSING		42,720					
CPA FIRM	COST REPORT		1,280					
CPA FIRM	990 & AG990 IL & W-2'S		2,715					
TEMPLIN HEALTHCARE	MEDICAR COST REPORT		2,601					
TELLATIN, SHORT & HANSEN, I	APPRAISAL FEE		4,410					
ARI INCORPORATED	NEW BUILDING CONSTRUC		7,000					
POLSINELLI, SHALTON	LEGAL		1,181					
BILL NICHELSON, ATTY	LEGAL		390					
BILL WILSON	COMPUTER CONSULTING		17,317					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 84,864					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning: 0701/14

Ending: 06/30/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ASSN BROTHERS CARE GIVERS 600; LEADING AGE IL 5,329
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 235,423
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? NO Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: GREGORY M. BIERMAN, CPA
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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. YES
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

SCHEDULE XI. OWNERSHIP COSTS: PAGE 11

FACILITY GROUNDS CONSIST OF 5.58 ACRES
ORIGINALLY THE LAND WAS SECURED BY DONATION IN 1905 BUT DESIGNATED AS HOME SITE IN 1975
AT WHICH TIME IT WAS APPRAISED AT A VALUATION OF \$28,500

SCHEDULE XI. OWNERSHIP COSTS: PAGE 12, 12A, 12B, 12C, 12D, 12E

IMPROVEMENTS:

SYSTEM DOES NOT DISTINGUISH BY YEAR, ONLY BY ASSET CLASSIFICATION.

STATE OF ILLINOIS

Page 25

Facility Name & ID Number BRETHREN HOME OF GIRARD DBA PLEASAI # 0021014 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

<u>NAME</u>	<u>DATE</u>	<u>LOCATION</u>	<u>TITLE</u>	<u>SPONSOR</u>	<u>REGISTRATION</u>	<u>MEALS</u>	<u>LODGING</u>	<u>TRAVEL</u>	<u>MILEAGE</u>
DRENDA HALEY	8/1/2014	SPRINGFIELD	HRD	FRED PRYOR SEMINAF	249				27
CATHY VOLLMER	9/11/2014	SPRINGFIELD	RN	SIU SCHOOL OF MEDIC	85			24	120
DAWN SMITH	9/12/2014	SPRINGFIELD	DIR FINANCE	NATIONAL GOV'T SER\	150				
PAULETTE MILLER	9/30/2015	LISLE	EX DIR	LSN	355		363	325	
HAROLD HAVRON	10/1/2014	PEORIA	FOOD SUPEF	ILLINOIS ANFP	75		49	80	
KAMI HOPPER	10/13/2014	CHICAGO	ADMINISTRA'	NASRM	147				
AMY HAMPTON	10/24/2014	BREESE	SOCIAL SER\	OUTCOME SERVICES	200				
PAULETTE MILLER	10/31/2014	CHICAGO	EX DIR	LSN			602		
KAMI HOPPER	1/5/2015	GIRARD	ADMINISTRA'	LSN	99				
BETH CHURCH	1/30/2015	SPRINGFIELD	LPN	SIU SCHOOL OF MEDIC	90				28
DAWN SMITH	1/31/2015	GIRARD	DIR FINANCE	LSN	99				
DAWN SMITH	1/31/2015	NASHVILLE	DIR FINANCE	BLR HCPRO	695		210		
PAULETTE MILLER			ADMINISTRATOR						
DARRIN BURNETT	1/31/2015	SPRINGFIELD	DEVELOPME	LSN	250				41
KAMI HOPPER	2/5/2015	OAK PARK	ADMINISTRA'	IL NURSING HOME ADI	95		127		69
CORY WOODRING	2/25/2015	SPRINGFIELD	HSK/LAUND	{ CAREER TRACK	149				
PAULETTE MILLER	2/27/2015	GIRARD	EX DIR	LSN	99				
DARRIN BURNETT	2/28/2015	INDIANAPOLIS	DEVELOPME	IUBL	1,260	98	511		118
ANN BEELER	3/4/2015	HIGHLAND	ACTIVITY DIR	OUTCOME SERVICES (500		178		210
DAWN SMITH	3/5/2015	GIRARD	DIR FINANCE	LSN	125				
DAWN SMITH	3/19/2015	NASHVILLE	DIR FINANCE	NIU OUTREACH	996	11			32
VARIOUS EMPLOYEES	3/26/2015	GIRARD	VARIOUS	AMY NIEHAUS-CPR	210				
KAMI HOPPER	4/21/2015	CHICAGO	ADMINISTRA'	LSN		103	451		139
DRENDA HALEY	4/30/2015	CHICAGO	HRD	LSN			409		155
MICHELLE CHENEY	5/7/2015	CHICAGO	DON	LEADING AGE	139				
VARIOUS EMPLOYEES	5/14/2015	GIRARD	VARIOUS	AMY NIEHAUS-CPR	355				
VARIOUS EMPLOYEES	6/4/2015	GIRARD	VARIOUS	DR QUARTON		101			
					6,422	313	2,900	429	939
									11,003

Facility Name & ID Number BRETHREN HOME OF GIRARD DBA PLEASAI # 0021014 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

STATEMENT OF LEGAL FEES

<u>FIRM NAME</u>	<u>DATE</u>	<u>ALLOWABLE AMOUNT</u>	<u>NON-ALLOWABLE</u>	<u>DESCRIPTION OF SERVICES</u>
POLSINELLI PC	7/11/2014	585		PROPERTY TAX EXEMPTION LITIGATION
BILL NICHELSON ATTORNI	8/4/2014	390		GUARDIANSHIP ISSUES
POLSINELLI PC	1/30/2015	596		IDOR HEARING AND APPEALS
TOTAL LEGAL FEES		<u>1571</u>		