I. IDPH License ID Number: 0021014

Facility Name: PLEASANT HILL VILLAGE
Address: 1010 W NORTH STREET GIRARD 62640
County: MACOUPIN
Telephone Number: (217) 627-2181 Fax # (217) 627-3401
HFS ID Number:   

Date of Initial License for Current Owners: 03/07/1976

Type of Ownership:

X VOLUNTARY, NON-PROFIT PROPRIETARY GOVERNMENTAL

C Charitable Corp. Individual State
Trust Partnership County
Corporation Other
"Sub-S" Corp. Limited Liability Co. Trust
Other

IRS Exemption Code 501 (C) (3)

In the event there are further questions about this report, please contact:
Name: PAULETTE BUCH-MILLER Telephone Number: (217) 627-9502
Email Address: 

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/15 to 06/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider (Signed) 10/28/2016
Type or Print Name PAULETTE BUCH-MILLER (Date)
Title EXECUTIVE DIRECTOR

Paid Preparer (Signed)  
(Print Name and Title) SEE ATTACHED PREPARATION REPORT
(Firm Name & Address) 
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS’ PREPARATION REPORT
### 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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds at Beginning of Report Period</td>
<td>Licensure Level of Care</td>
<td>Beds at End of Report Period</td>
<td>Licensed Bed Days During Report Period</td>
</tr>
<tr>
<td>1</td>
<td>98</td>
<td>Skilled (SNF)</td>
<td>98</td>
</tr>
<tr>
<td>2</td>
<td>Skilled Pediatric (SNF/PED)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Intermediate (ICF)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Intermediate/DD</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Sheltered Care (SC)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ICF/DD 16 or Less</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>98</td>
<td>TOTALS</td>
<td>98</td>
</tr>
</tbody>
</table>

**B. Census-For the entire report period.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care</td>
<td>Patient Days by Level of Care and Primary Source of Payment</td>
<td>Medicaid Recipient</td>
<td>Private Pay</td>
<td>Other</td>
</tr>
<tr>
<td>8</td>
<td>SNF</td>
<td>14,115</td>
<td>14,687</td>
<td>2,336</td>
</tr>
<tr>
<td>9</td>
<td>SNF/PED</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>ICF</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>ICF/DD</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>SC</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>DD 16 OR LESS</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>TOTALS</td>
<td>14,115</td>
<td>14,687</td>
<td>2,336</td>
</tr>
</tbody>
</table>

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

| 14,115 | 14,687 | 2,336 | 31,138 | 86.81% |

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

YES | NO | X

**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 | X

**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 2,336

**Medicare Intermediary**

NATIONAL GOVERNMENT SERVICES

**IV. ACCOUNTING BASIS**

MODIFIED

<table>
<thead>
<tr>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCEURAL</td>
<td>X</td>
<td>CASH*</td>
<td></td>
<td>CASH*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Tax Year: 06/30/2016 Fiscal Year: 06/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT
<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassification</th>
<th>Reclassified Total</th>
<th>Adjustments</th>
<th>Adjusted Total</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. General Services</td>
<td>Salary/Wage 1</td>
<td>Supplies 2</td>
<td>Other 3</td>
<td>Total 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Dietary</td>
<td>232,340</td>
<td>10,880</td>
<td>9,504</td>
<td>252,724</td>
<td>252,724</td>
<td>252,724</td>
</tr>
<tr>
<td>2. Food Purchase</td>
<td>218,469</td>
<td></td>
<td>218,469</td>
<td>(715) 217,754</td>
<td>217,754</td>
<td>217,754</td>
</tr>
<tr>
<td>3. Housekeeping</td>
<td>96,662</td>
<td>11,478</td>
<td>114,780</td>
<td>114,780</td>
<td>114,780</td>
<td>114,780</td>
</tr>
<tr>
<td>4. Laundry</td>
<td>71,155</td>
<td>11,749</td>
<td>5,133</td>
<td>88,037</td>
<td>88,037</td>
<td>88,037</td>
</tr>
<tr>
<td>5. Heat and Other Utilities</td>
<td>117,104</td>
<td>117,104</td>
<td>(1,948) 115,156</td>
<td>115,156</td>
<td>115,156</td>
<td>115,156</td>
</tr>
<tr>
<td>6. Maintenance</td>
<td>81,303</td>
<td>8,420</td>
<td>13,525</td>
<td>103,248</td>
<td>(9,018) 94,230</td>
<td>94,230</td>
</tr>
<tr>
<td>7. Other (specify):*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. TOTAL General Services</td>
<td>481,460</td>
<td>267,636</td>
<td>145,266</td>
<td>894,362</td>
<td>(715) 892,414</td>
<td>892,414</td>
</tr>
<tr>
<td>B. Health Care and Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Medical Director</td>
<td></td>
<td></td>
<td>17,956</td>
<td>17,956</td>
<td>17,956</td>
<td>17,956</td>
</tr>
<tr>
<td>10. Nursing and Medical Records</td>
<td>1,548,857</td>
<td>77,726</td>
<td>230,677</td>
<td>2,057,260</td>
<td>2,057,260</td>
<td>2,057,260</td>
</tr>
<tr>
<td>11. Activities</td>
<td>85,588</td>
<td>4,235</td>
<td>93,836</td>
<td>93,836</td>
<td>93,836</td>
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</tr>
<tr>
<td>12. Social Services</td>
<td>34,413</td>
<td></td>
<td>34,413</td>
<td>34,413</td>
<td>34,413</td>
<td>34,413</td>
</tr>
<tr>
<td>13. CNA Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Program Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Other (specify):* CHAPLAIN</td>
<td>33,459</td>
<td>190</td>
<td>33,649</td>
<td>33,649</td>
<td>33,649</td>
<td>33,649</td>
</tr>
<tr>
<td>16. TOTAL Health Care and Programs</td>
<td>1,764,737</td>
<td>82,151</td>
<td>629,915</td>
<td>2,476,803</td>
<td>2,476,803</td>
<td>2,476,803</td>
</tr>
<tr>
<td>C. General Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Administrative</td>
<td>172,433</td>
<td></td>
<td>172,433</td>
<td>(14,038) 158,395</td>
<td>158,395</td>
<td>158,395</td>
</tr>
<tr>
<td>18. Directors Fees</td>
<td></td>
<td></td>
<td>122,205</td>
<td>122,205</td>
<td>122,205</td>
<td>122,205</td>
</tr>
<tr>
<td>20. Clerical &amp; General Office Expenses</td>
<td>78,272</td>
<td>24,781</td>
<td>102,053</td>
<td>120,871</td>
<td>(8,154) 112,717</td>
<td>112,717</td>
</tr>
<tr>
<td>21. Employee Benefits &amp; Payroll Taxes</td>
<td>311,892</td>
<td>311,892</td>
<td>311,892</td>
<td>311,892</td>
<td>311,892</td>
<td>311,892</td>
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<tr>
<td>22. Inservice Training &amp; Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Travel and Seminar</td>
<td>5,201</td>
<td>5,201</td>
<td>5,201</td>
<td>5,201</td>
<td>5,201</td>
<td>5,201</td>
</tr>
<tr>
<td>24. Other (specify):** DEVELOPMENT &amp;</td>
<td>99,437</td>
<td></td>
<td>99,437</td>
<td>(14,528) 84,909</td>
<td>84,909</td>
<td>84,909</td>
</tr>
<tr>
<td>25. TOTAL General Administration</td>
<td>350,142</td>
<td>24,781</td>
<td>633,263</td>
<td>1,008,186</td>
<td>1,008,186</td>
<td>1,008,186</td>
</tr>
<tr>
<td>26. TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</td>
<td>2,596,339</td>
<td>374,568</td>
<td>1,408,444</td>
<td>4,379,351</td>
<td>4,377,403</td>
<td>4,305,921</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th>Reclassification</th>
<th>Reclassified Total</th>
<th>Adjustments</th>
<th>Adjusted Total</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage 1</td>
<td>Supplies 2</td>
<td>Other 3</td>
<td>Total 4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>D. Ownership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Depreciation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>86,514</td>
<td>86,514</td>
</tr>
<tr>
<td>31 Amortization of Pre-Op. &amp; Org.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Interest</td>
<td></td>
<td></td>
<td>16,213</td>
<td>16,213</td>
<td>16,213</td>
<td>(2,379)</td>
</tr>
<tr>
<td>33 Real Estate Taxes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42,378</td>
<td>42,378</td>
</tr>
<tr>
<td>34 Rent-Facility &amp; Grounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 Rent-Equipment &amp; Vehicles</td>
<td>3,528</td>
<td>3,528</td>
<td></td>
<td></td>
<td>3,528</td>
<td>3,528</td>
</tr>
<tr>
<td>36 Other (specify):*</td>
<td></td>
<td></td>
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<tr>
<td>Ancillary Expense</td>
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<tr>
<td>E. Special Cost Centers</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>38 Medically Necessary Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 Ancillary Service Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Barber and Beauty Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10,494</td>
<td>10,494</td>
</tr>
<tr>
<td>41 Coffee and Grill Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,948</td>
<td>1,948</td>
</tr>
<tr>
<td>42 Provider Participation Fee</td>
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<td></td>
<td></td>
<td></td>
<td>227,962</td>
<td>227,962</td>
</tr>
<tr>
<td>43 Other (specify):*</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44 TOTAL Special Cost Centers</td>
<td></td>
<td></td>
<td>238,456</td>
<td>238,456</td>
<td>1,948</td>
<td>240,404</td>
</tr>
<tr>
<td>45 GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</td>
<td></td>
<td>2,596,339</td>
<td>374,568</td>
<td>1,795,533</td>
<td>4,766,440</td>
<td></td>
</tr>
</tbody>
</table>

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

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471
## 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.)

<table>
<thead>
<tr>
<th>NON-ALLOWABLE EXPENSES</th>
<th>1. Amount</th>
<th>2. Reference</th>
<th>3. BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Day Care</td>
<td>$1,122</td>
<td></td>
<td>$1</td>
</tr>
<tr>
<td>2. Other Care for Outpatients</td>
<td>$2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3. Governmental Sponsored Special Programs</td>
<td>$3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>4. Non-Patient Meals</td>
<td>$(715)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>5. Telephone, TV &amp; Radio in Resident Rooms</td>
<td>$(3,990)</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>6. Rented Facility Space</td>
<td>$(1,700)</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>7. Sale of Supplies to Non-Patients</td>
<td>$7</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>8. Laundry for Non-Patients</td>
<td>$8</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>9. Non-Straightline Depreciation</td>
<td>$9</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>10. Interest and Other Investment Income</td>
<td>$(2,379)</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>11. Discounts, Allowances, Rebates &amp; Refunds</td>
<td>$11</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>12. Non-Working Officer's or Owner's Salary</td>
<td>$12</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>13. Sales Tax</td>
<td>$13</td>
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<td>13</td>
</tr>
<tr>
<td>14. Non-Care Related Interest</td>
<td>$14</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>15. Non-Care Related Owner's Transactions</td>
<td>$15</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>16. Personal Expenses (Including Transportation)</td>
<td>$16</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>17. Non-Care Related Fees</td>
<td>$17</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>18. Fines and Penalties</td>
<td>$(676)</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>19. Entertainment</td>
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<td>19</td>
</tr>
<tr>
<td>20. Contributions</td>
<td>$20</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>21. Owner or Key-Man Insurance</td>
<td>$21</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>22. Special Legal Fees &amp; Legal Retainers</td>
<td>$22</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>23. Malpractice Insurance for Individuals</td>
<td>$23</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>24. Bad Debt</td>
<td>$24</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>25. Fund Raising, Advertising and Promotional</td>
<td>$(22,561)</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>26. Income Taxes and Illinois Personal Property Replacement Tax</td>
<td>$26</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>27. CNA Training for Non-Employees</td>
<td>$27</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>28. Yellow Page Advertising</td>
<td>$(2,468)</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>29. Other-Attach Schedule</td>
<td>$29</td>
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<td>29</td>
</tr>
<tr>
<td>30. SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>$34,489</td>
<td></td>
<td>$30</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Amount</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Non-Paid Workers-Attach Schedule*</td>
<td>$31</td>
</tr>
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<td>Donated Goods-Attach Schedule*</td>
<td>$32</td>
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<tr>
<td>Amortization of Organization &amp; Pre-Operating Expense</td>
<td>$33</td>
</tr>
<tr>
<td>Adjustments for Related Organization Costs (Schedule VII)</td>
<td>$(39,372)</td>
</tr>
<tr>
<td>Other- Attach Schedule</td>
<td>$35</td>
</tr>
<tr>
<td>SUBTOTAL (B): (sum of lines 31-35)</td>
<td>$(39,372)</td>
</tr>
<tr>
<td>TOTAL ADJUSTMENTS (A) and (B)</td>
<td>$(73,861)</td>
</tr>
</tbody>
</table>

*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.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. Medically Necessary Transport.</td>
<td>X</td>
</tr>
<tr>
<td>39.</td>
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</tr>
<tr>
<td>40. Gift and Coffee Shops</td>
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</tr>
<tr>
<td>41. Barber and Beauty Shops</td>
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</tr>
<tr>
<td>42. Laboratory and Radiology</td>
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<td>43. Prescription Drugs</td>
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<td>45. Other-Attach Schedule</td>
<td>45</td>
</tr>
<tr>
<td>46. Other-Attach Schedule</td>
<td>46</td>
</tr>
<tr>
<td>47. TOTAL (C): (sum of lines 38-46)</td>
<td>$1,948</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' PREPARATION REPORT

---

**HFS 3745 (N-4-99)**

**IL478-2471**
## Sch. V Line Non-Allowable Expenses

<table>
<thead>
<tr>
<th>Amount Reference</th>
<th>Amount</th>
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<td><strong>Total</strong></td>
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</table>
## Operating Expenses

<table>
<thead>
<tr>
<th>Facility Name &amp; ID Number</th>
<th>Facility Name &amp; ID Number</th>
<th>Summary of PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I</th>
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<tbody>
<tr>
<td>A. General Services</td>
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<tr>
<td>1 Dietary</td>
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<td>2 Food Purchase</td>
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<tr>
<td>3 Housekeeping</td>
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<tr>
<td>4 Laundry</td>
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<td>5 Heat and Other Utilities</td>
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<tr>
<td>6 Maintenance</td>
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<td>7 Other (specify):*</td>
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<tr>
<td>8 TOTAL General Services</td>
<td>(715) (9,018) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 (9,733)</td>
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<tr>
<td>B. Health Care and Programs</td>
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<td>9 Medical Director</td>
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<td>10 Nursing and Medical Records</td>
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<tr>
<td>11a Therapy</td>
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<tr>
<td>11 Activities</td>
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<tr>
<td>12 Social Services</td>
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<td>13 CNA Training</td>
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<td>14 Program Transportation</td>
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<td>15 Other (specify):*</td>
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<td>16 TOTAL Health Care and Programs</td>
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<tr>
<td>C. General Administration</td>
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<tr>
<td>17 Administrative</td>
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<td>18 Directors Fees</td>
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<td>19 Professional Services</td>
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<td>20 Fees, Subscriptions &amp; Promotions</td>
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</tr>
<tr>
<td>21 Clerical &amp; General Office Expenses</td>
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<tr>
<td>22 Employee Benefits &amp; Payroll Taxes</td>
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<td>23 Inservice Training &amp; Education</td>
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<td>24 Travel and Seminar</td>
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<td>25 Other Admin. Staff Transportation</td>
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<td>26 Insurance-Prop.Liab.Malpractice</td>
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<tr>
<td>28 TOTAL General Administration</td>
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<tr>
<td>29 TOTAL Operating Expense (sum of lines 16 &amp; 28)</td>
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</tbody>
</table>

**Summary:**

- **Operating Expenses Total:** $71,482
- **General Services Total:** $61,749
- **Health Care and Programs Total:** $10,733
- **General Administration Total:** $16,000
- **Total:** $71,482

**Notes:**

- SCH V, COL. 7
- HFS 3745 (N-4-99) IL478-2471
<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>PAGES 5 &amp; 5A</th>
<th>PAGE 6</th>
<th>PAGE 6A</th>
<th>PAGE 6B</th>
<th>PAGE 6C</th>
<th>PAGE 6D</th>
<th>PAGE 6E</th>
<th>PAGE 6F</th>
<th>PAGE 6G</th>
<th>PAGE 6H</th>
<th>PAGE 6I</th>
<th>SUMMARY TOTALS (to Sch V, col.7)</th>
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<tr>
<td>D. Ownership</td>
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<td>35 Rent-Equipment &amp; Vehicles</td>
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<td>E. Special Cost Centers</td>
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<td>(73,861)</td>
</tr>
</tbody>
</table>

HFS 3745 (N-4-99)  IL478-2471
### 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.

<table>
<thead>
<tr>
<th>OWNERS</th>
<th>RELATED NURSING HOMES</th>
<th>OTHER RELATED BUSINESS ENTITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Ownership %</td>
<td>Name</td>
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<td>N/A</td>
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</tr>
<tr>
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</tr>
</tbody>
</table>

#### 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.

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</tr>
</tbody>
</table>

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

SEE ACCOUNTANTS' PREPARATION REPORT
### VII. RELATED PARTIES

A. (Continued)  

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

<table>
<thead>
<tr>
<th>1</th>
<th>OWNERS</th>
<th>Ownership %</th>
<th>Name</th>
<th>City</th>
<th>2</th>
<th>RELATED NURSING HOMES</th>
<th>City</th>
<th>Name</th>
<th>3</th>
<th>OTHER RELATED BUSINESS ENTITIES</th>
<th>Type of Business</th>
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</tbody>
</table>

SEE ACCOUNTANTS' PREPARATION 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Schedule V, Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N/A</td>
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TOTAL $ 13

* If the owner(s) of this facility or any other related party 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 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' PREPARATION REPORT
**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.)

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<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>X</th>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Item</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6 Units</th>
<th>Allocation (col.8/col.4)x col.6</th>
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SEE ACCOUNTANTS' PREPARATION REPORT
## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

### A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

<table>
<thead>
<tr>
<th></th>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate</th>
<th>Reporting Period Interest Expense</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>FIRST NATIONAL BANK OF RAY</td>
<td>X</td>
<td>OPERATING CAPITAL</td>
<td>11/30/14</td>
<td>400,075</td>
<td>11/30/15</td>
<td>0.0450</td>
<td>4,973</td>
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<td>2</td>
<td>FIRST NATIONAL BANK OF RAY</td>
<td>X</td>
<td>OPERATING CAPITAL</td>
<td>11/30/15</td>
<td>600,075</td>
<td>11/30/16</td>
<td>0.0450</td>
<td>10,744</td>
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<tr>
<td>3</td>
<td>VARIOUS VENDORS</td>
<td>X</td>
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<td>496</td>
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<td>4</td>
<td>TOTAL Facility Related</td>
<td></td>
<td>Long-Term</td>
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<td></td>
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<td>$1,000,150</td>
<td>$599,391</td>
<td>$16,213</td>
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<td>TOTAL Non-Facility Related*</td>
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<td>TOTALS (line 9+line14)</td>
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<td>$1,000,150</td>
<td>$599,391</td>
<td>$16,213</td>
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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.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)
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 2015 report. $78,616 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.) $52,804 2

3. Under or (over) accrual (line 2 minus line 1). $(25,812) 3

4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.) $68,190 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.) $25,000 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.) $25,000 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6. $42,378 7

Real Estate Tax History:

<table>
<thead>
<tr>
<th>Year</th>
<th>Tax Bill Amount</th>
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<tbody>
<tr>
<td>2011</td>
<td>44,614</td>
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<td>2012</td>
<td>51,385</td>
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<td>2013</td>
<td>52,411</td>
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<tr>
<td>2014</td>
<td>45,460</td>
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FOR BHF USE ONLY

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM R. E. TAX STATEMENT FOR 2015</td>
<td>$42,378</td>
</tr>
<tr>
<td>PLUS APPEAL COST FROM LINE 5</td>
<td>$25,000</td>
</tr>
<tr>
<td>LESS REFUND FROM LINE 6</td>
<td>$0</td>
</tr>
<tr>
<td>AMOUNT TO USE FOR RATE CALCULATION</td>
<td>$18,378</td>
</tr>
</tbody>
</table>

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' PREPARATION REPORT
## A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

<table>
<thead>
<tr>
<th>(A) Tax Index Number</th>
<th>(B) Property Description</th>
<th>(C) Total Tax</th>
<th>(D) Tax Applicable to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 07-000-313-00</td>
<td>S29 T12R6 OFF S SIDE SW</td>
<td>$ 53,333.90</td>
<td>$ 45,460.00</td>
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</tr>
<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<tr>
<td>9.</td>
<td></td>
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</tr>
<tr>
<td>10.</td>
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<td></td>
</tr>
</tbody>
</table>

**TOTALS**

|               |               | $ 53,333.90   | $ 45,460.00                      |

## B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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: 26,000

B. General Construction Type:
   - Exterior: BRICK
   - Frame: STEEL & FIRE RESISTANT

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: 

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

XI. OWNERSHIP COSTS:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Use</td>
<td>Square Feet</td>
<td>Year Acquired</td>
<td>Cost</td>
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<tr>
<td>FACILITY &amp; GROUNDS</td>
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<td>1905 - 1975/</td>
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<td>TOTALS</td>
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<td>$28,500</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' PREPARATION REPORT
### B. Building and Improvement Costs-Including Fixed Equipment (See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Cost</th>
<th>Life in Years</th>
<th>Depreciation</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
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<td>9 LANDSCAPING, FA SYSTEM PHYS SIGN DIRECTORY BOARD</td>
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<td>10 DIRECTORY BOARD LETTERS, PATIO CEMENT, LANDSCAPING</td>
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<td>12 LANDSCAPING, FENCE, CABINETS, INTERCOM, &amp; MIKE MIXER</td>
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<tr>
<td>13 REMODELING</td>
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<td>14 ENERGY CONTROL SYSTEM, REMODELING</td>
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<tr>
<td>15 CABINETS</td>
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<td>16 CABINET TOP</td>
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<td>17 GARAGE SHOP, STORAGE BLDL, REMODELING, DRIVEWAY</td>
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<td>18 REMODELING</td>
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<td>20 FIRE ALARM</td>
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<td>21 NEW ROOF, STORM WINDOWS, PAVILION</td>
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<td>25 SECURITY SYSTEM, REMODELING</td>
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<tr>
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<td>$40,250</td>
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<td>28 ROOF, WATERLINE, COVERBASE, &amp; HAND RAIL</td>
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<td>29 LANDSCAPING</td>
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<td>30 ROOF TOP AIR CONDITIONER</td>
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<td>35 EXHAUST FAN</td>
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<td>36 WATER HYDRANT</td>
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</table>

*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' Preparation Report.

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**HFS 3745 (N-4-99)**

**IL478-2471**
### B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
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<tr>
<td>42 WALL TREATMENTS &amp; PICTURES</td>
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<td>52 WINDOW TREATMENT</td>
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<td>53 CARPET</td>
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<tr>
<td>54 HEATING &amp; COOLING SYSTEM</td>
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<tr>
<td>55 ROOF TOP AIR CONDITIONER</td>
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<tr>
<td>56 LANDSCAPING</td>
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<tr>
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<td>66 MASTER PLAN</td>
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</tbody>
</table>

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

TOTAL (lines 4 thru 69) $1,912,193 $56,000 $56,000 $1,814,530

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99) IL478-2471
State of Illinois  

Facility Name & ID Number: PLEASANT HILL VILLAGE  0021014 

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

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
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<tbody>
<tr>
<td>Totals from Page 12A, Carried Forward</td>
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<td>$1,912,193</td>
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<td>$56,000</td>
<td>$1,814,530</td>
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**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS’ PREPARATION REPORT
### COSTS (continued)

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

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SEE ACCOUNTANTS’ PREPARATION REPORT

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**STATE OF ILLINOIS**

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

**Report Period:**

- **Beginning:** 07/01/15
- **Ending:** 06/30/16

**Page 12C**

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**HFS 3745 (N-4-99)**

IL478-2471
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

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SEE ACCOUNTANTS’ PREPARATION REPORT
### Ownership Costs

#### Building and Improvement Costs-Including Fixed Equipment

Round all numbers to nearest dollar.

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<tr>
<td>9 5 HEATING/CoolING UNITS</td>
<td>2015</td>
<td>5,031</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 CABINETS</td>
<td>2015</td>
<td>600</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 AIR CONDITIONERS</td>
<td>2015</td>
<td>3,406</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 ROOM DOORS</td>
<td>2015</td>
<td>2,372</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 FLOORING</td>
<td>2016</td>
<td>2,758</td>
<td></td>
<td></td>
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<td>14</td>
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<tr>
<td>33</td>
<td></td>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34 TOTAL (lines 1 thru 33)</td>
<td></td>
<td>$2,379,888</td>
<td>$56,000</td>
<td>$56,000</td>
<td>$1,814,530</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SEE ACCOUNTANTS' PREPARATION REPORT

---

HFS 3745 (N-4-99) IL478-2471
XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

<table>
<thead>
<tr>
<th>Category of Equipment</th>
<th>1 Cost</th>
<th>2 Current Book Depreciation</th>
<th>3 Straight Line Depreciation</th>
<th>4 Adjustments</th>
<th>Component Life</th>
<th>5 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased in Prior Years</td>
<td>$257,921</td>
<td>$28,495</td>
<td>$28,495</td>
<td>VARIOUS</td>
<td>$114,392</td>
<td>71</td>
</tr>
<tr>
<td>Current Year Purchases</td>
<td>33,462</td>
<td>2,019</td>
<td>2,019</td>
<td>VARIOUS</td>
<td>2,019</td>
<td>72</td>
</tr>
<tr>
<td>Fully Depreciated Assets</td>
<td>641,131</td>
<td></td>
<td></td>
<td>VARIOUS</td>
<td>641,131</td>
<td>73</td>
</tr>
<tr>
<td>TOTALS</td>
<td>$932,514</td>
<td>$30,514</td>
<td>$30,514</td>
<td></td>
<td>$757,542</td>
<td>75</td>
</tr>
</tbody>
</table>

D. Vehicle Costs. (See instructions.)*

<table>
<thead>
<tr>
<th>Model, Make and Year</th>
<th>2 Acquired</th>
<th>3 Cost</th>
<th>4 Current Book Depreciation</th>
<th>5 Straight Line Depreciation</th>
<th>6 Adjustments</th>
<th>7 Life in Years</th>
<th>8 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENTIAL OUTINGS BUS</td>
<td>2003</td>
<td>$57,588</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$57,588</td>
</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td></td>
<td></td>
<td>$57,588</td>
<td>$57,588</td>
<td>77</td>
<td></td>
</tr>
</tbody>
</table>

E. Summary of Care-Related Assets

<table>
<thead>
<tr>
<th>Description</th>
<th>Reference</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Historical Cost</td>
<td>(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)</td>
<td>$3,398,490</td>
</tr>
<tr>
<td>Current Book Depreciation</td>
<td>(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)</td>
<td>$86,514</td>
</tr>
<tr>
<td>Straight Line Depreciation</td>
<td>(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)</td>
<td>$86,514</td>
</tr>
<tr>
<td>Adjustments</td>
<td>(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)</td>
<td>$84</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)</td>
<td>$2,629,660</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description &amp; Year Acquired</th>
<th>2 Cost</th>
<th>3 Current Book Depreciation</th>
<th>4 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
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<tr>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

G. Construction-in-Progress

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' PREPARATION REPORT

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
** This must agree with Schedule V line 30, column 8.
XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
   [ ] YES  [ ] NO

<table>
<thead>
<tr>
<th>1 Year Constructed</th>
<th>2 Number of Beds</th>
<th>3 Original Lease Date</th>
<th>4 Rental Amount</th>
<th>5 Total Years of Lease</th>
<th>6 Total Years Renewal Option*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Building: $</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Additions</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>5</td>
<td></td>
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<tr>
<td>6</td>
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<td></td>
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<tr>
<td>7 TOTAL: **</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

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

C. Vehicle Rental (See instructions.)

<table>
<thead>
<tr>
<th>1 Use</th>
<th>2 Model Year and Make</th>
<th>3 Monthly Lease Payment</th>
<th>4 Rental Expense for this Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>$</td>
<td>$</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td>18</td>
</tr>
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<td>19</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>21 TOTAL: $</td>
<td></td>
<td>$</td>
<td>21</td>
</tr>
</tbody>
</table>

** SEE ACCOUNTANTS' PREPARATION 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.

1. **HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?**
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   **AIDES WERE ALREADY TRAINED**

#### B. EXPENSES

**ALLOCATION OF COSTS**

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

(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.

#### 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

<table>
<thead>
<tr>
<th></th>
<th>COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>From this facility</td>
</tr>
<tr>
<td>2</td>
<td>From other facilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>DROP-OUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>From this facility</td>
</tr>
<tr>
<td>2</td>
<td>From other facilities</td>
</tr>
</tbody>
</table>

TOTAL TRAINED

(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' PREPARATION REPORT
### XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

<table>
<thead>
<tr>
<th></th>
<th>Schedule V Line &amp; Column Reference</th>
<th>Service</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>L 10A; C3</td>
<td>Licensed Occupational Therapist</td>
<td>hrs</td>
<td>7,457</td>
<td>$</td>
<td>158,452</td>
<td>$</td>
<td>7,457</td>
<td>$</td>
<td>158,452</td>
</tr>
<tr>
<td>2</td>
<td>L 10A; C3</td>
<td>Licensed Speech and Language Development Therapist</td>
<td>hrs</td>
<td>1,390</td>
<td>46,683</td>
<td>1,390</td>
<td>46,683</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Licensed Recreational Therapist</td>
<td>hrs</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>L 10A; C3</td>
<td>Licensed Physical Therapist</td>
<td>hrs</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Physician Care</td>
<td>visits</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Dental Care</td>
<td>visits</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Work Related Program</td>
<td>hrs</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Habilitation</td>
<td>hrs</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Pharmacy</td>
<td># of prescrpts</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Psychological Services (Evaluation and Diagnosis/ Behavior Modification)</td>
<td>hrs</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Academic Education</td>
<td>hrs</td>
<td>8,312</td>
<td>172,134</td>
<td>8,312</td>
<td>172,134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>TOTAL</td>
<td>$17,159</td>
<td>$377,269</td>
<td>$17,159</td>
<td>$377,269</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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' PREPARATION REPORT
## XV. BALANCE SHEET - Unrestricted Operating Fund.

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

### A. Current Assets

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>Operating</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cash on Hand and in Banks</td>
<td>$947,673</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>Cash-Patient Deposits</td>
<td>2,296</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Accounts &amp; Short-Term Notes Receivable-Patients (less allowance)</td>
<td>2,027,226</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Supply Inventory (priced at COST)</td>
<td>6,019</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Short-Term Investments</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Prepaid Insurance</td>
<td>40,763</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Other Prepaid Expenses</td>
<td>995</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Accounts Receivable (owners or related parties)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other(specific):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>TOTAL Current Assets (sum of lines 1 thru 9)</td>
<td>$3,024,972</td>
<td>$</td>
</tr>
</tbody>
</table>

### B. Long-Term Assets

| 11 | Long-Term Notes Receivable |  |  |
| 12 | Long-Term Investments |  |  |
| 13 | Land | 28,500 |  |
| 14 | Buildings, at Historical Cost | 2,227,992 |  |
| 15 | Leasehold Improvements, at Historical Cost | 152,404 |  |
| 16 | Equipment, at Historical Cost | 989,597 |  |
| 17 | Accumulated Depreciation (book methods) | (2,629,527) |  |
| 18 | Deferred Charges |  |  |
| 19 | Organization & Pre-Operating Costs | 29,505 |  |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs | (13,763) |  |
| 21 | Restricted Funds | 81,781 |  |
| 22 | Other Long-Term Assets (specify) | 200,019 |  |
| 23 | Other(specific): FARMLAND | 60,000 |  |
| 24 | TOTAL Long-Term Assets (sum of lines 11 thru 23) | $1,126,508 | $ |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | $4,151,480 | $ |

### C. Current Liabilities

| 26 | Accounts Payable | $546,197 | $ |
| 27 | Officer's Accounts Payable |  |  |
| 28 | Accounts Payable-Patient Deposits | 2,296 |  |
| 29 | Short-Term Notes Payable | 599,391 |  |
| 30 | Accrued Salaries Payable | 105,063 |  |
| 31 | Accrued Taxes Payable (excluding real estate taxes) |  |  |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | 68,190 |  |
| 33 | Accrued Interest Payable |  |  |
| 34 | Deferred Compensation |  |  |
| 35 | Federal and State Income Taxes |  |  |
| 36 | Other Current Liabilities(specific): |  |  |
| 37 |  |  |  |
| 38 | TOTAL Current Liabilities (sum of lines 26 thru 37) | $1,321,137 | $ |

### D. Long-Term Liabilities

| 39 | Long-Term Notes Payable |  |  |
| 40 | Mortgage Payable |  |  |
| 41 | Bonds Payable |  |  |
| 42 | Deferred Compensation |  |  |
| 43 | Other Long-Term Liabilities(specific): |  |  |
| 44 |  |  |  |
| 45 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) |  |  |
| 46 | TOTAL LIABILITIES (sum of lines 38 and 45) | $1,321,137 | $ |
| 47 | TOTAL EQUITY(page 18, line 24) | $2,830,343 | $ |
| 48 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | $4,151,480 | $ |

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)
### XVI. STATEMENT OF CHANGES IN EQUITY

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Balance at Beginning of Year, as Previously Reported</strong></td>
<td><strong>$ 2,769,156</strong></td>
</tr>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Balance at Beginning of Year, as Restated (sum of lines 1-5)</strong></td>
<td><strong>$ 2,769,156</strong></td>
</tr>
</tbody>
</table>

**A. Additions (deductions):**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td><strong>NET Income (Loss) (from page 19, line 43)</strong></td>
<td><strong>$ 61,187</strong></td>
</tr>
<tr>
<td>8</td>
<td>Acquisitions of Pooled Companies</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Proceeds from Sale of Stock</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Stock Options Exercised</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Contributions and Grants</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Expenditures for Specific Purposes</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Dividends Paid or Other Distributions to Owners</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Donated Property, Plant, and Equipment</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td><strong>TOTAL Additions (deductions) (sum of lines 7-16)</strong></td>
<td><strong>$ 61,187</strong></td>
</tr>
</tbody>
</table>

**B. Transfers (Itemize):**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td><strong>TOTAL Transfers (sum of lines 18-22)</strong></td>
<td><strong>$ 2,830,343</strong></td>
</tr>
<tr>
<td>24</td>
<td><strong>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</strong></td>
<td><strong>$ 2,830,343</strong></td>
</tr>
</tbody>
</table>

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION 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. Revenue

<table>
<thead>
<tr>
<th>I. Inpatient Care</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Gross Revenue -- All Levels of Care</td>
<td>$4,755,674</td>
</tr>
<tr>
<td>2 Discounts and Allowances for all Levels</td>
<td>(28,654)</td>
</tr>
<tr>
<td>3 SUBTOTAL Inpatient Care (line 1 minus line 2)</td>
<td>$4,727,020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Ancillary Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Day Care</td>
</tr>
<tr>
<td>5 Other Care for Outpatients</td>
</tr>
<tr>
<td>6 Therapy</td>
</tr>
<tr>
<td>7 Oxygen</td>
</tr>
<tr>
<td>8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Other Operating Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Payments for Education</td>
</tr>
<tr>
<td>10 Other Government Grants</td>
</tr>
<tr>
<td>11 CNA Training Reimbursements</td>
</tr>
<tr>
<td>12 Grill and Coffee Shop</td>
</tr>
<tr>
<td>13 Barber and Beauty Care</td>
</tr>
<tr>
<td>14 Non-Patient Meals</td>
</tr>
<tr>
<td>15 Telephone, Television and Radio</td>
</tr>
<tr>
<td>16 Rental of Facility Space</td>
</tr>
<tr>
<td>17 Sale of Drugs</td>
</tr>
<tr>
<td>18 Sale of Supplies to Non-Patients</td>
</tr>
<tr>
<td>19 Laboratory</td>
</tr>
<tr>
<td>20 Radiology and X-Ray</td>
</tr>
<tr>
<td>21 Other Medical Services</td>
</tr>
<tr>
<td>22 Laundry</td>
</tr>
<tr>
<td>23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Non-Operating Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Contributions</td>
</tr>
<tr>
<td>25 Interest and Other Investment Income***</td>
</tr>
<tr>
<td>26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Other Revenue (specify):****</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 Settlement Income (Insurance, Legal, Etc.)</td>
</tr>
<tr>
<td>28 REIMBURSEMENT 32,892; ENDOWMENT FUND 2,125</td>
</tr>
<tr>
<td>29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)</td>
</tr>
<tr>
<td>30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</td>
</tr>
</tbody>
</table>

### 2. Expenses

<table>
<thead>
<tr>
<th>H. Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 General Services</td>
<td>894,362</td>
</tr>
<tr>
<td>32 Health Care</td>
<td>2,476,803</td>
</tr>
<tr>
<td>33 General Administration</td>
<td>1,008,186</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Capital Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 Ownership</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Ancillary Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 Special Cost Centers</td>
</tr>
<tr>
<td>36 Provider Participation Fee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Other Expenses (specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
</tr>
<tr>
<td>38</td>
</tr>
<tr>
<td>39</td>
</tr>
</tbody>
</table>

| 40 TOTAL EXPENSES (sum of lines 31 thru 39)* | $4,766,440 |

| 41 Income before Income Taxes (line 30 minus line 40)** | 61,187 |

| 42 Income Taxes | |

| 43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | $61,187 |

### III. Net Inpatient Revenue detailed by Payer Source

| 44 Medicaid - Net Inpatient Revenue | $1,892,749 |
| 45 Private Pay - Net Inpatient Revenue | 1,767,303 |
| 46 Medicare - Net Inpatient Revenue | 1,095,622 |
| 47 Other-(specify) CHARITABLE CARE | (28,654) |
| 48 Other-(specify) | |

| 49 TOTAL Inpatient Care Revenue (This total must agree to Line 3) | $4,727,020 |

---

* 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.
### B. CONSULTANT SERVICES

<table>
<thead>
<tr>
<th>Number of Hrs.</th>
<th>Total Consultant Cost for Reporting Period</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hrs. Paid &amp; Accrued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>1,933</td>
<td>$ 73,450</td>
</tr>
<tr>
<td>Assistant Director of Nursing</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>7,888</td>
<td>195,115</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>28,936</td>
<td>436,920</td>
</tr>
<tr>
<td>CNAs &amp; Orderlies</td>
<td>77,744</td>
<td>843,372</td>
</tr>
<tr>
<td>CNA Trainees</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Dietary Consultant</td>
<td>176</td>
<td>$ 9,504</td>
</tr>
<tr>
<td>Medical Director</td>
<td>126</td>
<td>17,956</td>
</tr>
<tr>
<td>Medical Records Consultant</td>
<td>20</td>
<td>518</td>
</tr>
<tr>
<td>Nurse Consultant</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Pharmacist Consultant</td>
<td>123</td>
<td>6,174</td>
</tr>
<tr>
<td>Physical Therapy Consultant</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Consultant</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy Consultant</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy Consultant</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Activity Consultant</td>
<td>58</td>
<td>4,013</td>
</tr>
<tr>
<td>Social Service Consultant</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Other(specify)</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Other(specify)</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Other(specify)</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>TOTAL (lines 35 - 48)</td>
<td>503</td>
<td>$ 38,165</td>
</tr>
<tr>
<td>Medical Director</td>
<td>37</td>
<td>$ 1,854</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>702</td>
<td>24,585</td>
</tr>
<tr>
<td>Certified Nurse Assistants/Aides</td>
<td>3,208</td>
<td>66,559</td>
</tr>
<tr>
<td>TOTAL (lines 50 - 52)</td>
<td>3,947</td>
<td>$ 92,998</td>
</tr>
</tbody>
</table>

### C. CONTRACT NURSES

<table>
<thead>
<tr>
<th>Number of Hrs.</th>
<th>Total Contract Wages</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hrs. Paid &amp; Accrued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor of Nursing</td>
<td>1,924</td>
<td>33,459</td>
</tr>
<tr>
<td>Chaplain</td>
<td>1,818</td>
<td>1,924</td>
</tr>
<tr>
<td>DEVELOPMENT</td>
<td>3,891</td>
<td>4,143</td>
</tr>
</tbody>
</table>

| TOTAL (lines 34 - 33) | 169,279 | 180,497 | $ 2,596,339 | $ 14.38 | 34 |

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

** See instructions.
STATE OF ILLINOIS  
PLEASANT HILL VILLAGE  
Facility Name & ID Number: PLEASANT HILL VILLAGE # 0021014

Report Period Beginning: 07/01/15  
Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries  
Name: PAULETTE BUCH-MILLER  
Function: EXECUTIVE DIRECTOR  
Percentage: 0%  
Amount: $87,225

- Workers' Compensation Insurance: $73,797
- IDPH License Fee: $1,990
- Unemployment Compensation Insurance: $5,279
- FICA Taxes: $195,955
- Employee Health Insurance: $18,269

Name: KAMI HOPPER  
Function: ADMINISTRATOR  
Percentage: 0%  
Amount: $76,266

- Unemployment Compensation Insurance: $5,279
- Advertising: Employee Recruitment: $12,918
- Health Care Worker Background Check: $1,661

Name: MARY ANN WALKER  
Function: ADMINISTRATOR  
Percentage: 0%  
Amount: $8,942

- FICA Taxes: $195,955
- MUR & Background Check: $510

TOTAL (agree to Schedule V, line 17, col. 1): $172,433

B. Administrative - Other

- Total (agree to Schedule V, line 17, col. 3): $122,205

C. Professional Services

- CPA FIRM AUDIT: $5,410
- CPA FIRM DATA PROCESSING: $14,840
- CPA FIRM COST REPORT: $1,320
- CPA FIRM: 990, AG990IL, W-2S: $2,800
- ARI, INC NEW BUILDING PLANS: $15,786
- BLDD ARCHITECTS NEW BUILDING PLANS: $6,153
- JOHN CRAWFORD & ASSOC NEW BUILDING PLANS: $7,500
- BILL WILSON COMPUTER CONSULTING: $4,442
- TEMPLIN HEALTHCARE MEDICARE COST REPORT: $2,093
- POLSINELLI SHALTON LEGAL: $32,661

TOTAL (agree to Schedule V, line 19, column 3): $122,205

D. Employee Benefits and Payroll Taxes

- Workers' Compensation Insurance: $73,797
- Unemployment Compensation Insurance: $5,279
- FICA Taxes: $195,955
- Employee Health Insurance: $18,269

TOTAL (agree to Schedule V, line 17, col. 1): $311,892

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

- Out-of-State Travel: $5,201
- In-State Travel: $5,201
- Seminar Expense: $5,201

TOTAL: $32,474

F. Dues, Fees, Subscriptions and Promotions

- IDPH License Fee: $1,990
- Advertising: Employee Recruitment: $12,918
- DUES - ASSOCIATION: $5,396
- DUES OTHER: $9,422

TOTAL: $32,474

G. Schedule of Travel and Seminar**

- Entertainment Expense: $5,201

TOTAL: $32,474

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT
Facility Name & ID Number: PLEASANT HILL VILLAGE

STATE OF ILLINOIS

Report Period Beginning: 07/01/15 Ending: 06/30/16

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

(3) Did the nursing home make political contributions or payments to a political action organization? NO

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO

(5) Have you properly capitalized all major repairs and equipment purchases? YES

(6) Indicate the total amount of both disposable and non-disposable diaper expenses 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

(8) Are you presently operating under a sale and leaseback arrangement? NO

(9) Are you presently operating under a sublease agreement? YES

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 227,962

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO

(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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0

(16) Travel and Transportation
   a. Are there costs included for out-of-state travel? NO
   b. Do you have a separate contract with the Department to provide medical transportation for residents? NO
   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

(17) Has an audit been performed by an independent certified public accounting firm? YES

(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? YES

SEE ACCOUNTANTS' PREPARATION REPORT
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

IMPROVEMENTS:

SYSTEM DOES NOT DISTINGUISH BY YEAR, ONLY BY ASSET CLASSIFICATION.
<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
<th>LOCATION</th>
<th>TITLE</th>
<th>SPONSOR</th>
<th>REGISTRATION</th>
<th>MEALS</th>
<th>LODGING</th>
<th>TRAVEL</th>
<th>MILEAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kami Hopper</td>
<td>7/1/2015</td>
<td>Medina</td>
<td>Administra Alice Training Institute</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dawn Smith</td>
<td>7/8/2015</td>
<td>Mokena</td>
<td>Dir Finance LSN</td>
<td></td>
<td></td>
<td>550</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kami Hopper</td>
<td>8/6/2015</td>
<td>Peoria</td>
<td>Administra INHAA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>111</td>
<td>64</td>
</tr>
<tr>
<td>Dawn Smith</td>
<td>8/13/2015</td>
<td>Tinley Park</td>
<td>Dir Finance Medicare Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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HFS 3745 (N-4-99)  IL478-2471
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**TOTAL LEGAL FEES**

| 32,661 |