

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0021014

Facility Name: PLEASANT HILL VILLAGE

Address: 1010 W NORTH STREET GIRARD 62640
Number City Zip Code

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:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (C) (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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
(Date)

(Type or Print Name) PAULETTE BUCH-MILLER

(Title) EXECUTIVE DIRECTOR

Paid
Preparer

(Signed)
(Date)

(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

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,868</u>	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	<u>98</u>	TOTALS	<u>98</u>	<u>35,868</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,115</u>	<u>14,687</u>	<u>2,336</u>	<u>31,138</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,115</u>	<u>14,687</u>	<u>2,336</u>	<u>31,138</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.81%

SEE ACCOUNTANTS' PREPARATION REPORT

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 2,336

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: 06/30/2016 Fiscal Year: 06/30/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PLEASANT HILL VILLAGE** # **0021014** Report Period Beginning: **07/01/15** Ending: **06/30/16**

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	232,340	10,880	9,504	252,724		252,724		252,724			1
2	Food Purchase		218,469		218,469		218,469	(715)	217,754			2
3	Housekeeping	96,662	18,118		114,780		114,780		114,780			3
4	Laundry	71,155	11,749	5,133	88,037		88,037		88,037			4
5	Heat and Other Utilities			117,104	117,104	(1,948)	115,156		115,156			5
6	Maintenance	81,303	8,420	13,525	103,248		103,248	(9,018)	94,230			6
7	Other (specify):*											7
8	TOTAL General Services	481,460	267,636	145,266	894,362	(1,948)	892,414	(9,733)	882,681			8
	B. Health Care and Programs											
9	Medical Director			17,956	17,956		17,956		17,956			9
10	Nursing and Medical Records	1,548,857	77,726	230,677	1,857,260		1,857,260		1,857,260			10
10a	Therapy	62,420		377,269	439,689		439,689		439,689			10a
11	Activities	85,588	4,235	4,013	93,836		93,836		93,836			11
12	Social Services	34,413			34,413		34,413		34,413			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* CHAPLAIN	33,459	190		33,649		33,649		33,649			15
16	TOTAL Health Care and Programs	1,764,737	82,151	629,915	2,476,803		2,476,803		2,476,803			16
	C. General Administration											
17	Administrative	172,433			172,433		172,433	(14,038)	158,395			17
18	Directors Fees											18
19	Professional Services			122,205	122,205		122,205		122,205			19
20	Dues, Fees, Subscriptions & Promotions			57,503	57,503		57,503	(25,029)	32,474			20
21	Clerical & General Office Expenses	78,272	24,781	17,818	120,871		120,871	(8,154)	112,717			21
22	Employee Benefits & Payroll Taxes			311,892	311,892		311,892		311,892			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,201	5,201		5,201		5,201			24
25	Other Admin. Staff Transportation			2,037	2,037		2,037		2,037			25
26	Insurance-Prop.Liab.Malpractice			116,607	116,607		116,607		116,607			26
27	Other (specify):* DEVELOPMENT & I	99,437			99,437		99,437	(14,528)	84,909			27
28	TOTAL General Administration	350,142	24,781	633,263	1,008,186		1,008,186	(61,749)	946,437			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,596,339	374,568	1,408,444	4,379,351	(1,948)	4,377,403	(71,482)	4,305,921			29

*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)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			86,514	86,514		86,514		86,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,213	16,213		16,213	(2,379)	13,834			32
33	Real Estate Taxes			42,378	42,378		42,378		42,378			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			148,633	148,633		148,633	(2,379)	146,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					1,948	1,948		1,948			40
41	Coffee and Gift Shops			10,494	10,494		10,494		10,494			41
42	Provider Participation Fee			227,962	227,962		227,962		227,962			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			238,456	238,456	1,948	240,404		240,404			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,596,339	374,568	1,795,533	4,766,440		4,766,440	(73,861)	4,692,579			45

*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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(715)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,990)	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	(2,379)	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	(676)	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	(22,561)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,468)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (34,489)		\$	30

BHF USE ONLY							
48		49		50		51	

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 Amount	2 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)	(39,372)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (39,372)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (73,861)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		1,948	5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,948		47

SEE ACCOUNTANTS' PREPARATION REPORT

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(715)	0	0	0	0	0	0	0	0	0	0	(715)	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	(9,018)	0	0	0	0	0	0	0	0	0	(9,018)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(715)	(9,018)	0	0	0	0	0	0	0	0	0	(9,733)	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	(14,038)	0	0	0	0	0	0	0	0	0	(14,038)	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	(25,029)	0	0	0	0	0	0	0	0	0	0	(25,029)	20
21	Clerical & General Office Expenses	(6,366)	(1,788)	0	0	0	0	0	0	0	0	0	(8,154)	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	(14,528)	0	0	0	0	0	0	0	0	0	(14,528)	27
28	TOTAL General Administration	(31,395)	(30,354)	0	0	0	0	0	0	0	0	0	(61,749)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(32,110)	(39,372)	0	0	0	0	0	0	0	0	0	(71,482)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,379)	0	0	0	0	0	0	0	0	0	0	(2,379)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,379)	0	0	0	0	0	0	0	0	0	0	(2,379)	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)	(34,489)	(39,372)	0	0	0	0	0	0	0	0	0	(73,861)	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	GIRARD	INDEPENDENT &
				RESIDENCE		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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	ADMINISTRATOR WAGES	\$			\$	\$ (14,038)	1
2	V	27	DEVELOPMENT & MARKETING WAGES					(14,528)	2
3	V	21	CLERICAL WAGES (ADDITION)					4,692	3
4	V	6	MAINTENANCE WAGES					(9,018)	4
5	V	21	OFFICE SPACE RENT					(6,480)	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			\$			\$	\$ * (39,372)	14

* 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

	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
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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' PREPARATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

SEE ACCOUNTANTS' 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.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	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							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6	FIRST NATIONAL BANK OF RAYM	X		OPERATING CAPITAL		11/30/14	400,075		11/30/15	0.0450	4,973	6							
7	FIRST NATIONAL BANK OF RAYM	X		OPERATING CAPITAL		11/30/15	600,075	599,391	11/30/16	0.0450	10,744	7							
8	VARIOUS VENDORS		X								496	8							
9	TOTAL Facility Related						\$ 1,000,150	\$ 599,391				\$ 16,213	9						
	B. Non-Facility Related*																		
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$				\$	14						
15	TOTALS (line 9+line14)						\$ 1,000,150	\$ 599,391				\$ 16,213	15						

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' PREPARATION 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)			\$		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.			\$	42,378	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012	44,614	9	
		2013	51,385	10	
		2014	52,411	11	
		2015	45,460	12	
REAL ESTATE TAX ACCRUED AT 6/30/16 WAS FIGURED FOR JANUARY-DECEMBER 2015 ACTUAL BILL 45,460 PLUS					
JANUARY - JUNE 2016 (45460/12x6=22,730) (45460+22730=68190) TAXES FOR 2015 WERE NOT PAID UNTIL AUGUST AND					
SEPTEMBER OF 2016 (AFTER FISCAL YEAR END)					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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' PREPARATION REPORT

FACILITY NAME	PLEASANT HILL VILLAGE	COUNTY	MACOUPIN
---------------	-----------------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT PAULETTE BUCH-MILLER

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000

B. General Construction Type: Exterior BRICKFrame STEEL & FIRE RESISTANTNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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: 1903 - 1976

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY & GROUNDS	243,065	1905 - 1975*	\$ 28,500	1
2					2
3	TOTALS	243,065		\$ 28,500	3

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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	\$ 16,267	40	\$ 16,267	\$	\$ 975,998	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING, PA SYSTEM PHV SIGN DIRECTORY BOARD			1976	5,916						9
10	DIRECTORY BOARD LETTERS, PATIO CEMENT, LANDSCAPING			1977	1,273						10
11	LANDSCAPING, AIR CONDITIONER, FLAG PLE LIGHT			1978	6,194						11
12	LANDSCAPING, FENCE, CABINETS, INTERCOM, & MIKE MIXER			1980	3,688						12
13	REMODELING			1981	485						13
14	ENERGY CONTROL SYSTEM, REMODELING			1982	19,060						14
15	CABINETS			1983	271						15
16	CABINET TOP			1984	408						16
17	GARAGE SHOP, STORAGE BLDG, REMODELING, DRIVEWAY			1985	74,072	39,733	VARIOUS	39,733		838,532	17
18	REMODELING			1986	5,469						18
19	BACKFLOW PREVENTOR, WINDOW, & MIXING VALVE			1989	8,180						19
20	FIRE ALARM			1991	1,298						20
21	NEW ROOF, STORM WINDOWS, PAVILION			1992	61,405						21
22	LANDSCAPING			1993	1,240						22
23	LANDSCAPING, ROOF			1994	43,344						23
24	NEW ROOF, REMODELING, AIR CONDITIONERS			1994	32,226						24
25	SECURITY SYSTEM, REMODELING			1994	6,907						25
26	ARCHITECH, REMODELING, A/C, CARPET, FLOOR, PAINT & PAP			1995	40,250						26
27	DRIVEWAY, ARCHITECH, LANDSCAPING, A/C WINDOW TREATM			1995	28,013						27
28	ROOF, WATERLINE, COVEBASE, & HAND RAIL			1996	40,657						28
29	LANDSCAPING			1997	915						29
30	ROOF TOP AIR CONDITIONER			1997	6,795						30
31	PAINT & WALL PAPER			1997	24,720						31
32	FLOORING			1997	12,182						32
33	COVEBASE			1997	2,713						33
34	REPLACE CEILING			1997	16,220						34
35	EXHAUST FAN			1997	428						35
36	WATER HYDRANT			1997	527						36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 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 VINYL 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	\$ 56,000		\$ 56,000	\$	\$ 1,814,530	70

SEE ACCOUNTANTS' PREPARATION 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:

07/01/15

Ending:

06/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 1,912,193	\$ 56,000		\$ 56,000		\$ 1,814,530	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	\$ 56,000		\$ 56,000		\$ 1,814,530	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,023,533	\$ 56,000		\$ 56,000	\$	\$ 1,814,530	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 ANNUCIATOR 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	\$ 56,000		\$ 56,000	\$	\$ 1,814,530	34

SEE ACCOUNTANTS' PREPARATION 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	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	\$ 56,000		\$ 56,000		\$ 1,814,530	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 STAT	2013	9,549						33
34 TOTAL (lines 1 thru 33)		\$ 2,338,510	\$ 56,000		\$ 56,000		\$ 1,814,530	34

SEE ACCOUNTANTS' PREPARATION 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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 2,338,510	\$ 56,000		\$ 56,000	\$	\$ 1,814,530	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 CABINETS	2015	600						10
11 AIR CONDITIONERS	2015	3,406						11
12 ROOM DOORS	2015	2,372						12
13 FLOORING	2016	2,758						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)		\$ 2,379,888	\$ 56,000		\$ 56,000	\$	\$ 1,814,530	34

SEE ACCOUNTANTS' PREPARATION 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	\$ 257,921	\$ 28,495	\$ 28,495	\$	VARIOUS	\$ 114,392	71
72	Current Year Purchases	33,462	2,019	2,019		VARIOUS	2,019	72
73	Fully Depreciated Assets	641,131				VARIOUS	641,131	73
74								74
75	TOTALS	\$ 932,514	\$ 30,514	\$ 30,514	\$		\$ 757,542	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	BUS	2003	\$ 57,588	\$	\$	\$	5	\$ 57,588	76
77										77
78										78
79										79
80	TOTALS			\$ 57,588	\$	\$	\$		\$ 57,588	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,398,490	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,514	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,514	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)	\$ 2,629,660	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' PREPARATION 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

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' PREPARATION REPORT

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

AIDES WERE ALREADY TRAINED

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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' PREPARATION REPORT

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

		1	2		3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	L 10A; C3	hrs	\$	7,457	\$	158,452	\$	7,457	\$	158,452	1
2	Licensed Speech and Language Development Therapist	L 10A; C3	hrs		1,390		46,683		1,390		46,683	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	L 10A; C3	hrs		8,312		172,134		8,312		172,134	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			\$	17,159	\$	377,269	\$	17,159	\$	377,269	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' PREPARATION REPORT

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	\$ 947,673	\$	1
2	Cash-Patient Deposits	2,296		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 283,268)	2,027,226		3
4	Supply Inventory (priced at COST)	6,019		4
5	Short-Term Investments			5
6	Prepaid Insurance	40,763		6
7	Other Prepaid Expenses	995		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,024,972	\$	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	2,227,992		14
15	Leasehold Improvements, at Historical Cost	152,404		15
16	Equipment, at Historical Cost	989,597		16
17	Accumulated Depreciation (book methods)	(2,629,527)		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	81,781		21
22	Other Long-Term Assets (specify: CAPITAL CONTRIB	200,019		22
23	Other(specify): FARMLAND	60,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,126,508	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,151,480	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 546,197	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,296		28
29	Short-Term Notes Payable	599,391		29
30	Accrued Salaries Payable	105,063		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,190		32
33	Accrued Interest Payable			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)	\$ 1,321,137	\$	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)	\$ 1,321,137	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,830,343	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,151,480	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,769,156	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,769,156	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,187	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)	\$ 61,187	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)	\$ 2,830,343	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number PLEASANT HILL VILLAGE

0021014

Report Period Beginning: 07/01/15

Ending: 06/30/16

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	\$ 4,755,674	1
2	Discounts and Allowances for all Levels	(28,654)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,727,020	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	13,590	12
13	Barber and Beauty Care	1,948	13
14	Non-Patient Meals	715	14
15	Telephone, Television and Radio	3,990	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)	\$ 21,943	23
	D. Non-Operating Revenue		
24	Contributions	13,500	24
25	Interest and Other Investment Income***	2,379	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,879	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	REIMBURSEMENT 32,892; ENDOWMENT FUND 2,125	35,017	28
28a	FUND RAISING	27,768	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 62,785	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,827,627	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	894,362	31
32	Health Care	2,476,803	32
33	General Administration	1,008,186	33
	B. Capital Expense		
34	Ownership	148,633	34
	C. Ancillary Expense		
35	Special Cost Centers	10,494	35
36	Provider Participation Fee	227,962	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,766,440	40
41	Income before Income Taxes (line 30 minus line 40)**	61,187	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 61,187	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,892,749	44
45	Private Pay - Net Inpatient Revenue	1,767,303	45
46	Medicare - Net Inpatient Revenue	1,095,622	46
47	Other-(specify) CHARITABLE CARE	(28,654)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,727,020	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' PREPARATION REPORT

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	1,504	1,933	\$ 73,450	\$ 38.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,555	7,888	195,115	24.74	3
4	Licensed Practical Nurses	18,944	20,936	436,920	20.87	4
5	CNAs & Orderlies	74,024	77,744	843,372	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,221	3,619	62,420	17.25	8
9	Activity Director	3,501	3,822	50,931	13.33	9
10	Activity Assistants	3,856	4,027	34,657	8.61	10
11	Social Service Workers	2,477	2,679	34,413	12.85	11
12	Dietician					12
13	Food Service Supervisor	2,328	2,459	47,130	19.17	13
14	Head Cook	5,993	6,191	60,686	9.80	14
15	Cook Helpers/Assistants	11,939	12,244	117,224	9.57	15
16	Dishwashers	628	849	7,300	8.60	16
17	Maintenance Workers	4,217	4,502	81,303	18.06	17
18	Housekeepers	9,456	10,224	96,662	9.45	18
19	Laundry	6,646	7,140	71,155	9.97	19
20	Administrator	3,488	3,991	172,433	43.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,793	4,182	78,272	18.72	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 Care: CHAPLAIN	1,818	1,924	33,459	17.39	32
33	Other(specify) DEVELOPMENT	3,891	4,143	99,437	24.00	33
34	TOTAL (lines 1 - 33)	169,279	180,497	\$ 2,596,339 *	\$ 14.38	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	176	\$ 9,504	L1;C3	35
36	Medical Director	126	17,956	L9;C3	36
37	Medical Records Consultant	20	518	L10;C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	123	6,174	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	58	4,013	L11;C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	503	\$ 38,165		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	37	\$ 1,854	L10;C3	50
51	Licensed Practical Nurses	702	24,585	L10;C3	51
52	Certified Nurse Assistants/Aides	3,208	66,559	L10;C3	52
53	TOTAL (lines 50 - 52)	3,947	\$ 92,998		53

SEE ACCOUNTANTS' PREPARATION REPORT

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 BRETHREN CARE GIVERS 300; LEADING AGE 5096
- (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.

\$

227,962

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 benefit 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' PREPARATION 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 PLEASANT # 0021014 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

<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>
KAMI HOPPER	7/1/2015	MEDINA	ADMINISTRATOR	ALICE TRAINING INSTIT	595				
DAWN SMITH	7/8/2015	MOKENA	DIR FINANCE	LSN	550				
KAMI HOPPER	8/6/2015	PEORIA	ADMINISTRATOR	INHAA			111		64
DAWN SMITH	8/13/2015	TINLEY PARK	DIR FINANCE	MEDICARE TRAINING			404		123
KAMI HOPPER	8/15/2015	GIRARD	ADMINISTRATOR	HEALTH SERVICES CO	79				
ANN JOHNSTON	8/26/2015	SPRINGFIELD	COMM RELAT	ILLINOIS PIONEER COA	100				
CATHY VOLLMER	8/26/2015	SPRINGFIELD	RN	ILLINOIS PIONEER COA	205				
PAULETTE MILLER	3/13/2152	GIRARD	EX DIR	LSN	99				
KAMI HOPPER			ADMINISTRATOR						
DRENDA HALEY	10/6/2015	CHICAGO	HRD	PEACE CHRUCH	908				236
KAMI HOPPER	10/19/2015	GIRARD	ADMINISTRATOR	STI WEBINAR	110				
KAMI HOPPER	10/20/2015	AURORA	ADMINISTRATOR	IL NURSING HOME ADM	125				
PAULETTE MILLER	11/6/2015	PEORIA	EX DIR	LSN			77		
PAULETTE MILLER	11/9/2015	GIRARD	EX DIR	LSN	99				
PAULETTE MILLER	11/18/2015	GIRARD	EX DIR	LSN	325				
DARRIN BURNETT	4/15/2016	INDIANAPOLIS	DEVELOPME	CAPITAL CAMPAIGN					69
PAULETTE MILLER	5/4/2016	LISLE	EX DIR	LSN	272				
PAULETTE MILLER	5/20/2016	CHICAGO	EX DIR	PATHWAY HEALTH SEF	550				
VARIOUS EMPLOYEES	6/30/2016	GIRARD	DIETARY	FOOD HANDLERS LICE	10				
VARIOUS EMPLOYEES	6/30/2016	GIRARD	DIETARY	FOOD HANDLERS LICE	90				
					4,117	-	592	-	492
									5,201

Facility Name & ID Number BRETHREN HOME OF GIRARD DBA PLEASANT HILL # 0021014 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	10/6/15 - 10/30/15	7,030		PROPERTY TAX EXEMPTION APPEAL
POLSINELLI PC	11/3/2015	555		PROPERTY TAX EXEMPTION APPEAL
POLSINELLI PC	11/13/15 - 11/25/15	5,090		EMPLOYEE ABUSE, PERFORMANCE ISSUES
POLSINELLI PC	12/17/2015	188		PROPERTY TAX EXEMPTION APPEAL
POLSINELLI PC	11/2/2015	337		EMPLOYEE ABUSE ALLEGATION ISSUE
POLSINELLI PC	2/9/16 - 2/16/16	10,865		PROPERTY TAX EXEMPTION APPEAL
POLSINELLI PC	4/11/16-4/27/16	1,714		TAX EXEMPTION ISSUES, ABUSE RELATED ISSUES, BED DECERTIFICATION ISSUES
POLSINELLI PC	6/17/2016	6,882		PROPERTY TAX EXEMPTION APPEAL
TOTAL LEGAL FEES		<u>32,661</u>		