

		FOR BHF USE					

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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: 0012864 Facility Name: Pleasant View Luther Home Address: 505 College Avenue Ottawa 61350 County: Lasalle Telephone Number: (815) 434-1130 Fax # (815) 434-1135 HFS ID Number: Date of Initial License for Current Owners: 1/28/2013 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Deb Freeland

Telephone Number: 317-569-6230

Email Address:

Facility Name & ID Number Pleasant View Luther Home

0012864 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	4,957	16,908	6,663	28,528	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,957	16,908	6,663	28,528	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.84%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 6/28/1937

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 90 and days of care provided 5,316

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	523,509	37,178	8,226	568,913		568,913		568,913			1
2	Food Purchase		403,068		403,068		403,068	(107,352)	295,716			2
3	Housekeeping	160,495	32,247	595	193,337		193,337		193,337			3
4	Laundry	30,582	12,252		42,834		42,834		42,834			4
5	Heat and Other Utilities			310,832	310,832		310,832		310,832			5
6	Maintenance	166,925	24,234	321,476	512,635		512,635	(9,851)	502,784			6
7	Other (specify):*											7
8	TOTAL General Services	881,511	508,979	641,129	2,031,619		2,031,619	(117,203)	1,914,416			8
	B. Health Care and Programs											
9	Medical Director			15,620	15,620		15,620		15,620			9
10	Nursing and Medical Records	2,199,993	122,039	40,063	2,362,095		2,362,095	(3,960)	2,358,135			10
10a	Therapy											10a
11	Activities	122,165	3,739	7,857	133,761		133,761		133,761			11
12	Social Services	48,816	672	488	49,976		49,976		49,976			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,370,974	126,450	64,028	2,561,452		2,561,452	(3,960)	2,557,492			16
	C. General Administration											
17	Administrative			105,470	105,470	98,869	204,339		204,339			17
18	Directors Fees											18
19	Professional Services			52,523	52,523		52,523	(3,000)	49,523			19
20	Dues, Fees, Subscriptions & Promotions			23,719	23,719		23,719		23,719			20
21	Clerical & General Office Expenses	356,163	34,742	160,968	551,873	(98,869)	453,004	(50,779)	402,225			21
22	Employee Benefits & Payroll Taxes			859,421	859,421		859,421	(70,012)	789,409			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,378	9,378		9,378	(1,668)	7,710			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,319	28,319		28,319		28,319			26
27	Other (specify):*											27
28	TOTAL General Administration	356,163	34,742	1,239,798	1,630,703		1,630,703	(125,459)	1,505,244			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,608,648	670,171	1,944,955	6,223,774		6,223,774	(246,622)	5,977,152			29

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

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

STATE OF ILLINOIS

Part V Supplement

Facility Name & ID Num Pleasant View Luther Home # 0012864 Report Period Beginning 7/01/2014 Ending: 6/30/2015

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

		To Line	From Line
Reclassify administrative wages	\$ 98,869	17	21

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			1,219,392	1,219,392		1,219,392	(175,144)	1,044,248			30
31	Amortization of Pre-Op. & Org.			39,490	39,490		39,490		39,490			31
32	Interest			1,661,617	1,661,617		1,661,617	(45,317)	1,616,300			32
33	Real Estate Taxes			210,456	210,456		210,456	(124,645)	85,811			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,130,955	3,130,955		3,130,955	(345,106)	2,785,849			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		210,792	826,569	1,037,361		1,037,361		1,037,361			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,497	193,497		193,497		193,497			42
43	Other (specify):* Marketing/AL/IL	297,023	3,384	188,888	489,295		489,295	(489,295)				43
44	TOTAL Special Cost Centers	297,023	214,176	1,208,954	1,720,153		1,720,153	(489,295)	1,230,858			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,905,671	884,347	6,284,864	11,074,882		11,074,882	(1,081,023)	9,993,859			45

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

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	(87,435)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(9,851)	6		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	(45,317)	32		10
11	Discounts, Allowances, Rebates & Refunds	(19,917)	2		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				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	(50,779)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Other Non-allowable	(867,724)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,081,023)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,081,023)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Senior Fitness Revenue	\$ (3,960)	10	1
2				2
3				3
4	Luther Place and Estates/Marketing	(489,295)	43	4
5	Non-Allowable Depreciation	(175,144)	30	5
6	Marketing Benefits	(27,258)	22	6
7	AL Benefits	(42,754)	22	7
8	Marketing Transportation	(1,668)	24	8
9	Disallowed Professional Fees	(3,000)	19	9
10	Non-Allowable Real Estate Taxes	(124,645)	33	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	(867,724)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	(107,352)	0	0	0	0	0	0	0	0	0	0	(107,352)	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	(9,851)	0	0	0	0	0	0	0	0	0	0	(9,851)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(117,203)	0	0	0	0	0	0	0	0	0	0	(117,203)	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	(3,960)	0	0	0	0	0	0	0	0	0	0	(3,960)	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	(3,960)	0	0	0	0	0	0	0	0	0	0	(3,960)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(50,779)	0	0	0	0	0	0	0	0	0	0	(50,779)	21
22	Employee Benefits & Payroll Taxes	(70,012)	0	0	0	0	0	0	0	0	0	0	(70,012)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,668)	0	0	0	0	0	0	0	0	0	0	(1,668)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(125,459)	0	0	0	0	0	0	0	0	0	0	(125,459)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(246,622)	0	0	0	0	0	0	0	0	0	0	(246,622)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	(175,144)	0	0	0	0	0	0	0	0	0	0	(175,144)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(45,317)	0	0	0	0	0	0	0	0	0	0	(45,317)	32
33	Real Estate Taxes	(124,645)	0	0	0	0	0	0	0	0	0	0	(124,645)	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	(345,106)	0	0	0	0	0	0	0	0	0	0	(345,106)	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):*	(489,295)	0	0	0	0	0	0	0	0	0	0	(489,295)	43
44	TOTAL Special Cost Centers	(489,295)	0	0	0	0	0	0	0	0	0	0	(489,295)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,081,023)	0	0	0	0	0	0	0	0	0	0	(1,081,023)	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
Lutheran Home for the Aged Inc.	100	Lutheran Home for the Aged	Arlington Heights	Lutheran Life Ministri	Arlington Heights	Parent Holding Com
		Pleasant View Luther Home	Ottawa	Lutheran Life Commu	Arlington Heights	Management Consul
		St. Pauls House & Health Care Center	Chicago	Lutheran Foundation f	Arlington Heights	Fundraising
		Wittenberg Lutheran Village	Crown Point	Lutheran Community	Arlington Heights	Support Services
		Arlington of Naples	Naples			
		Luther Oaks	Bloomington			

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	Roger Paulsberg	Chairman	Administrative	0.00	278,115	3	7.50	Salary	\$ 22,550	17-3	1
2	Lori Fedyk	Treasurer	Administrative	0.00	180,765	4	10.00	Salary	20,085	17-3	2
3	Marie Carlson	Vice President	Administrative	0.00	209,138	2	5.00	Salary	11,007	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 53,642		13

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

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

Facility Name & ID Number Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

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		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										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

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				See Attached Schedule			\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6				See Attached Schedule								6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

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

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

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

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

B. Real Estate Taxes

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.		\$	144,047	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.)				\$	216,821	2
3. Under or (over) accrual (line 2 minus line 1).				\$	72,774	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	137,682	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.				\$	210,456	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011		8		
		2012		9		
		2013		10		
		2014		11		
		2015	203,280	12		
				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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pleasant View Luther Home COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0012864

CONTACT PERSON REGARDING THIS REPORT Charles Babec

TELEPHONE (815) 434-1130 FAX #: (815) 434-1135

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.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 22-14-416-016	1019 University Ave	\$ 3,015.84	\$
2. 22-14-401-019	505 College Ave	\$ 213,805.56	\$ 92,176.22
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 216,821.40	\$ 92,176.22

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 providecopies of their original second installment tax bill.

Pleasant View Luther Home
6/30/2016
RE Tax Allocation

<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
22-14-416-016	1019 University Ave - Vacant Lot	\$ 3,016	-
22-14-401-019	505 College Ave	\$ 213,806	92,176
22-77-014-004 - 10	928- 952 Pleasant View - Vacant Lot	\$ -	-

Allocation Calculation			
	Facility Units	Total Units	% Applicable to Nursing Home
Square Feet	72,788	168,834	43%

Tax Applicable to Nursing Home (Total Tax * Allocation %)			
Tax ID	Total Tax	Allocation %	
22-14-416-016	3,016	0%	-
22-14-401-019	213,806	43%	92,176
22-77-014-004 - 10	-	0%	-

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

125,137

B. General Construction Type:

Exterior

Brick

Frame

Brick-Concrete

Number of Stories

4

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).

Pleasant View Luther Place - Duplexes for Independent Living - 20 units available

Pleasant View Luther Estates - Duplexes for Independent Living - 14 units available

Pleasant View Hearthstone - Apartments for Assisted Living - 41 units available

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF	522,750		\$ 339,943	1
2					2
3	TOTALS	522,750		\$ 339,943	3

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	90		1957	1957	\$ 170,416	\$	40	\$	\$	4
5			1960	1960	64,957		40			5
6			1962	1962	767,743		40			6
7			1977	1977	3,768,795		40			7
8										8
	Improvement Type**									
9	1980 Building & Land Improvements			1980	8,096					9
10	1981 Building & Land Improvements			1981	95,606					10
11	1982 Building & Land Improvements			1982	109,621					11
12	1983 Building & Land Improvements			1983	52,137					12
13	1984 Building & Land Improvements			1984	51,282					13
14	1985 Building & Land Improvements			1985	68,023					14
15	1986 Building & Land Improvements			1986	12,076					15
16	1987 Building & Land Improvements			1987	82,723					16
17	1988 Building & Land Improvements			1988	7,182					17
18	1991 Building & Land Improvements			1991	12,726					18
19	1992 Building & Land Improvements			1992	41,495					19
20	1995 Building & Land Improvements			1995	21,584					20
21	1996 Building & Land Improvements			1996	196,509					21
22	1997 Building & Land Improvements			1997	37,277					22
23	2001 Building & Land Improvements			2001	47,645					23
24	2002 Building & Land Improvements			2002	1,370,163					24
25	2003 Building & Land Improvements			2003	6,130					25
26	2004 Building & Land Improvements			2004	5,098					26
27	2005 Building & Land Improvements			2005	1,350					27
28	2007 Building & Land Improvements			2007	176,083					28
29	2008 Building & Land Improvements			2008	23,938					29
30	2009 Building & Land Improvements			2009	30,277					30
31	2011 Building & Land Improvements			2011	15,506,066					31
32	Additional Scope / POC items for PH1 (Health Center)			2012	387,637					32
33	Hearthstone Building Additional Scope / POC			2012	169,132					33
34	Underground Water Pipe			2012	7,588					34
35	Hoffman Development Fees Ph1 and PH2			2013	51,157					35
36	Remote Fire Alarm Annunciator			2013	1,848					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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 Roof HVAC Silencer	2013	\$ 41,926	\$		\$	\$	\$	37
38 Hearthstone 17 unit addition PH4	2014	2,984,440						38
39 Village Square Building PH3	2014	5,220,883						39
40 Steps Voidfilled	2014	1,345						40
41 Bifold Doors	2015	3,660						41
42 Unith 101H Carpet	2015	3,348						42
43 Unit 103 Carpet	2015	2,107						43
44 Roof AC Unit	2016	4,761		10				44
45 Pipe Plumbing - Boiler Room	2016	3,862		10				45
46 Transistors in dining rooms	2016	681		5				46
47 Unit 207 carpet and flooring	2016	2,011		5				47
48 Sidewalk replacement	2016	14,875		15				48
49 Parking Lot Striping	2016	1,600		5				49
50 Sealcoat parking lot	2016	11,129		5				50
51								51
52								52
53 Financial Statement Depreciation			781,110		781,110		8,837,361	53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 31,648,988	\$ 781,110		\$ 781,110	\$	\$ 8,837,361	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,252,286	\$250,886	\$250,886	\$	Var	\$1,070,826	71
72	Current Year Purchases	76,753	4,410	4,410		Var	4,411	72
73	Fully Depreciated Assets	519,017				Var	519,017	73
74								74
75	TOTALS	\$2,848,056	\$255,296	\$255,296	\$		\$1,594,254	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	See Attachment			\$117,575	\$7,842	\$7,842	\$	Various	\$94,703	76
77										77
78										78
79										79
80	TOTALS			\$117,575	\$7,842	\$7,842	\$		\$94,703	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)	\$34,954,562	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,044,248	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,044,248	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)	\$10,526,318	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	Non-Allowable	\$3,781,979	\$175,144	\$2,675,302	86
87					87
88					88
89					89
90					90
91	TOTALS	\$3,781,979	\$175,144	\$2,675,302	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

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

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. /2017 \$
13. /2018 \$
14. /2019 \$

* 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.

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

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)	\$			

- (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.

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	

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		44,738	826,569		44,738	826,569	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				210,792		210,792	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			\$	44,738	\$ 826,569	\$ 210,792	44,738	\$ 1,037,361	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,780,276	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 92,129)	1,130,883		3
4	Supply Inventory (priced at)	44,322		4
5	Short-Term Investments	16,516		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	49,674		7
8	Accounts Receivable (owners or related parties)	(4,834,966)		8
9	Other(specify): Interest Receivable	2,400,894		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 587,599	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	347,068		13
14	Buildings, at Historical Cost	34,675,850		14
15	Leasehold Improvements, at Historical Cost	136,276		15
16	Equipment, at Historical Cost	3,237,404		16
17	Accumulated Depreciation (book methods)	(13,201,620)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	185,138		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing/Cost to Acqui 976,367			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,356,483	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,944,082	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 633,163	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	310,134		29
30	Accrued Salaries Payable	358,288		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,824		31
32	Accrued Real Estate Taxes(Sch.IX-B)	137,682		32
33	Accrued Interest Payable	204,565		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	344,844		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,002,500	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,597,779		39
40	Mortgage Payable	1,525,390		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	3,797,139		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,920,308	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 29,922,808	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,978,726)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 26,944,082	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,226,772)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,226,772)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	248,051	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) Rounding	(5)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 248,046	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)	\$ (2,978,726)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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	\$ 9,721,349	1
2	Discounts and Allowances for all Levels	(2,187,010)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,534,339	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,603,532	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,603,532	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	451	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	87,435	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	9,851	16
17	Sale of Drugs	196,769	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,908	19
20	Radiology and X-Ray	13,545	20
21	Other Medical Services	187,686	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 513,645	23
	D. Non-Operating Revenue		
24	Contributions	22,696	24
25	Interest and Other Investment Income***	90,337	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 113,033	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Attachment</u>	558,384	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 558,384	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,322,933	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,031,619	31
32	Health Care	2,561,452	32
33	General Administration	1,630,703	33
	B. Capital Expense		
34	Ownership	3,130,955	34
	C. Ancillary Expense		
35	Special Cost Centers	1,526,656	35
36	Provider Participation Fee	193,497	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,074,882	40
41	Income before Income Taxes (line 30 minus line 40)**	248,051	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 248,051	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 911,181	44
45	Private Pay - Net Inpatient Revenue	4,182,480	45
46	Medicare - Net Inpatient Revenue	236,480	46
47	Other-(specify) <u>AL/HMO/Free Care</u>	2,204,198	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,534,339	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

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	1,950	1,950	\$ 90,747	\$ 46.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,051	33,051	916,630	27.73	3
4	Licensed Practical Nurses	436	436	9,969	22.86	4
5	CNAs & Orderlies	74,245	74,245	966,571	13.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,849	7,849	112,544	14.34	10
11	Social Service Workers	3,723	3,723	69,774	18.74	11
12	Dietician	2,165	2,165	28,439	13.14	12
13	Food Service Supervisor	9,790	9,790	196,948	20.12	13
14	Head Cook	1,798	1,798	23,732	13.20	14
15	Cook Helpers/Assistants	25,613	25,613	239,838	9.36	15
16	Dishwashers	1,919	1,919	17,497	9.12	16
17	Maintenance Workers	8,545	8,545	168,319	19.70	17
18	Housekeepers	15,813	15,813	165,472	10.46	18
19	Laundry	3,320	3,320	34,708	10.45	19
20	Administrator	1,950	1,950	98,869	50.70	20
21	Assistant Administrator					21
22	Other Administrative	14,610	14,610	308,552	21.12	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,950	1,950	29,274	15.01	31
32	Other Health Care AL/IL/Marketing	14,573	14,573	225,888	15.50	32
33	Other(specify) Nursing Admin	8,692	8,692	201,900	23.23	33
34	TOTAL (lines 1 - 33)	231,992	231,992	\$ 3,905,671 *	\$ 16.84	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		\$		35
36	Medical Director	120	15,620	9-03	36
37	Medical Records Consultant	32	1,822	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	9,472	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	257	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	350	\$ 27,171		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number

Pleasant View Luther Home

STATE OF ILLINOIS

0012864

Report Period Beginning:

07/01/2015

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Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Becky Cattani		Executive Administrator	0	\$ 98,869	Workers' Compensation Insurance		\$ 135,951	IDPH License Fee		\$		
					Unemployment Compensation Insurance		83,921	Advertising: Employee Recruitment		2,413		
					FICA Taxes		287,980	Health Care Worker Background Check				
					Employee Health Insurance		339,019	(Indicate # of checks performed 89)		895		
					Employee Meals			Patient Background Checks		290		
					Illinois Municipal Retirement Fund (IMRF)*			Subscriptions & Publications		4,987		
					Retirement		5,499	Dues and Memberships		15,424		
					Life Insurance		7,903					
					Benefit Offset		(5,455)					
					Employee Physicals		4,437					
					403B		166	Less: Public Relations Expense		()		
					Less:Non-Reimburseable Benefits		(70,012)	Non-allowable advertising		()		
								Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 98,869	TOTAL (agree to Schedule V, line 22, col.8)				\$ 789,409	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 23,719
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount		
Management Fee			\$ 105,470					Out-of-State Travel		\$		
								In-State Travel		6,586		
								Seminar Expense		2,792		
								Less: Non-Reimburseable		(1,668)		
								Entertainment Expense		()		
								(agree to Sch. V, line 24, col. 8)				
								TOTAL		\$ 7,710		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 105,470	TOTAL				\$			
C. Professional Services												
Vendor/Payee		Type	Amount									
CliftonLarsonAllen		Accounting	\$ 14,816									
Arthur J. Gallagher RMS, Inc.		Renewal	700									
Chuhak & Tecson P.C.		Legal	3,573									
Easy Access LLC		Other	2,476									
Hupp, Lanuti, Irion & Burton		Legal	1,500									
Jeffrey Asset Management		Management Fees	(379)									
McVey & Parsky LLC		Legal	7,435									
Smith Affiliated Capital Corporation		Management Fees	521									
Smith, Hemmesch, Burke & Kaczynski		Tax Assessment	3,000									
Solaris Advisors LLC		Advisory Fees	772									
Wells Fargo		Trustee Fees	9,445									
Ziegler Capital Management LLC		Management Fees	8,664									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 52,523								

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>LEADING AGE \$8,192</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 Year</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>23,750</u> Line <u>10-2</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>193,497</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>87,435</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</u> d. Have vehicle usage logs been maintained? <u>Yes</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>CliftonLarsonAllen LLP</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u> (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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees
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