

		FOR OHF USE				

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0042416</u></p> <p><b>Facility Name:</b> <u>PLEASANT VIEW</u></p> <p><b>Address:</b> <u>500 NORTH JACKSON</u> <u>MORRISON</u> <u>61270</u>          Number City Zip Code</p> <p><b>County:</b> <u>WHITESIDE</u></p> <p><b>Telephone Number:</b> <u>815-772-7288</u> Fax # <u>815-772-2399</u></p> <p><b>IDPA ID Number:</b> <u>362819435003</u></p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>ALAN GAPINSKI</u> <b>Telephone Number:</b> <u>815-778-3683</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>ALAN GAPINSKI</u></td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>ALAN GAPINSKI</u>		(Title) _____	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
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<b>Paid Preparer</b>	(Signed) _____ (Date) _____																																						
	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) (____) _____ Fax # (____) _____																																						

Facility Name & ID Number PLEASANT VIEW# 0042416 Report Period Beginning: 01/01/00 Ending: 12/31/00

## 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 74

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	16,655	9,828		26,483	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,655	9,828		26,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 98.05%D. How many bed-hold days during this year were paid by Public Aid?  
218 (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)  
\_\_\_\_\_F. Does the facility maintain a daily midnight census? YESG. 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 12/6/96J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/6/96 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/00 Fiscal Year: 12/31/00  
\* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	147,268	13,449	4,520	165,237	414	165,651		165,651		1
2	Food Purchase		134,218		134,218		134,218	(2,967)	131,251		2
3	Housekeeping	48,726	13,777		62,503	173	62,676		62,676		3
4	Laundry	38,918	19,751		58,669	138	58,807		58,807		4
5	Heat and Other Utilities			56,138	56,138		56,138	(2,860)	53,278		5
6	Maintenance	46,234	20,095	13,357	79,686		79,686		79,686		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	281,146	201,290	74,015	556,451	725	557,176	(5,827)	551,349		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,125	2,125		2,125		2,125		9
10	Nursing and Medical Records	667,974	53,791	2,059	723,824	(12,700)	711,124		711,124		10
10a	Therapy	22,566		3,702	26,268		26,268		26,268		10a
11	Activities	45,547	4,409		49,956		49,956		49,956		11
12	Social Services	49,320		629	49,949		49,949		49,949		12
13	Nurse Aide Training			4,878	4,878	13,529	18,407		18,407		13
14	Program Transportation		2,096		2,096	(921)	1,175		1,175		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	785,407	60,296	13,393	859,096	(92)	859,004		859,004		16
	<b>C. General Administration</b>										
17	Administrative			84,533	84,533		84,533	(2,627)	81,906		17
18	Directors Fees										18
19	Professional Services			6,052	6,052		6,052	1,262	7,314		19
20	Dues, Fees, Subscriptions & Promotions			11,736	11,736		11,736	(3,276)	8,460		20
21	Clerical & General Office Expenses	34,694	8,833	16,169	59,696		59,696	2,139	61,835		21
22	Employee Benefits & Payroll Taxes			193,662	193,662	(1,554)	192,108	10,379	202,487		22
23	Inservice Training & Education			280	280		280		280		23
24	Travel and Seminar			5,339	5,339		5,339	721	6,060		24
25	Other Admin. Staff Transportation							557	557		25
26	Insurance-Prop.Liab.Malpractice			20,041	20,041		20,041		20,041		26
27	Other (specify):*			762	762		762	(762)			27
28	<b>TOTAL General Administration</b>	34,694	8,833	338,574	382,101	(1,554)	380,547	8,393	388,940		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,101,247	270,419	425,982	1,797,648	(921)	1,796,727	2,566	1,799,293		29

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

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

Facility Name &amp; ID Number

PLEASANT VIEW

#0042416

Report Period Beginning:

01/01/00

Ending:

12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			34,123	34,123		34,123	66,915	101,038		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			55,735	55,735		55,735	106,045	161,780		32
33	Real Estate Taxes			31,800	31,800		31,800		31,800		33
34	Rent-Facility & Grounds			155,697	155,697		155,697	(155,697)			34
35	Rent-Equipment & Vehicles			6,000	6,000		6,000		6,000		35
36	Other (specify):* <b>GOODWILL</b>			11,316	11,316		11,316	(11,316)			36
37	<b>TOTAL Ownership</b>			294,671	294,671		294,671	5,947	300,618		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation					921	921		921		38
39	Ancillary Service Centers		4,821		4,821		4,821		4,821		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,626	40,626		40,626		40,626		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		4,821	40,626	45,447	921	46,368		46,368		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,101,247	275,240	761,279	2,137,766		2,137,766	8,513	2,146,279		45

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

Facility Name & ID Number PLEASANT VIEW

# 0042416

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,967)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,860)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,960	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(762)	27		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				24
25	Fund Raising, Advertising and Promotional	(3,444)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(388)	20		28
29	Other-Attach Schedule SEE ATTACHED	(11,869)	21,36		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (12,330)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	20,843		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 20,843		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 8,513		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 921	14,38	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 921		47

ID# 0042416  
 Report Period Beginning: 01/01/00  
 Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1			1
2			2
3			3
4			4
5			5
6			6
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80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PLEASANT VIEW

# 0042416 Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,967)	0	0	0	0	0	0	0	0	0	0	(2,967)	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	(2,860)	0	0	0	0	0	0	0	0	0	0	(2,860)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,827)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,827)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	81,906	(84,533)	0	0	0	0	0	0	0	0	(2,627)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,262	0	0	0	0	0	0	0	0	0	1,262	19
20	Fees, Subscriptions & Promotions	(3,832)	556	0	0	0	0	0	0	0	0	0	(3,276)	20
21	Clerical & General Office Expenses	(553)	2,692	0	0	0	0	0	0	0	0	0	2,139	21
22	Employee Benefits & Payroll Taxes	0	10,379	0	0	0	0	0	0	0	0	0	10,379	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	721	0	0	0	0	0	0	0	0	0	721	24
25	Other Admin. Staff Transportation	0	557	0	0	0	0	0	0	0	0	0	557	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(762)	0	0	0	0	0	0	0	0	0	0	(762)	27
28	<b>TOTAL General Administration</b>	<b>(5,147)</b>	<b>98,073</b>	<b>(84,533)</b>	<b>0</b>	<b>8,393</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(10,974)</b>	<b>98,073</b>	<b>(84,533)</b>	<b>0</b>	<b>2,566</b>	<b>29</b>							



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BIG MEADOWS,INC.	100.00%	BIG MEADOWS,INC.	SAVANNA			
AMERICAN HEALTH ENTERPRISES,INC.	100.00%					
	0.00%	WINNING WHEELS,INC.	PROPHETSTOWN			
	0.00%	STRIVE	PROPHETSTOWN			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 155,697	OSO PARTNERS	100.00%	\$	\$ (155,697)	1
2	V	30 DEPRECIATION				54,322	54,322	2
3	V	32 MORTGAGE INTEREST				104,233	104,233	3
4	V	17 PROFESSIONAL SERVICES	84,533	AMERICAN HEALTH ENTERPRISES(OPERATION)	100.00%	102,518	17,985	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		\$ 240,230			\$ 261,073	\$ * 20,843	14

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

Facility Name & ID Number      PLEASANT VIEW      #      0042416      Report Period Beginning:      01/01/00      Ending:      12/31/00

## 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	AMERICAN HEALTH								\$		1
2	ENTERPRISES,INC.										2
3			DIRECT								3
4	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00%							4
5	PLEASANT VIEW			100.00%	20,285	10	20.00	MANAGEMENT	84,533	17,3	5
6	BIG MEADOWS, INC.			100.00%	28,398	14	28.00	FEES	123,547	N/A	6
7	WINNING WHEELS,INC.			0.00%	36,512	18	36.00	"	153,500	N/A	7
8	STRIVE			0.00%	10,142	5	10.00	"	93,500	N/A	8
9	OTHERS(NON COST REPORTING)			0.00%	6,085	3	6.00	"	84,000	N/A	9
10											10
11											11
12											12
13								TOTAL	\$ 539,080		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

# 0042416 Report Period Beginning: 01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC.  
 Street Address 501-6TH AVE WEST  
 City / State / Zip Code LYNDON, IL. 61261  
 Phone Number ( 815-778-3683  
 Fax Number ( 815-778-4503

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	DIRECT COST	1	\$ 37,985	\$ 37,985	1	\$ 37,985	1	
2	17	ADMINISTRATIVE	GROSS REVENUE	5	214,152	214,152	2,088,500	43,921	2	
3	19	DATA PROCESSING	GROSS REVENUE	5	3,958	0	2,088,500	812	3	
4	19	ACCOUNTING FEES	GROSS REVENUE	2	900	0	1	450	4	
5	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	5	1,618	0	2,088,500	332	5	
6	21	SUPPLIES, PHONE	GROSS REVENUE	5	13,125	0	2,088,500	2,692	6	
7	22	BENEFITS	DIRECT + % INDIRECT	429,478	5	71,623	0	81,886	10,379	7
8	24	TRAINING, SEMINARS	GROSS REVENUE	5	3,517	0	2,088,500	721	8	
9	25	ADMIN. TRANSPORTATION	GROSS REVENUE	5	2,717	0	2,088,500	557	9	
10	30	DEPR'N VEHICLES	GROSS REVENUE	5	7,990	0	2,088,500	1,639	10	
11	30	DEPR'N EQUIPMENT	GROSS REVENUE	5	4,849	0	2,088,500	994	11	
12	32	INTEREST (VEHICLES)	GROSS REVENUE	5	606	0	2,088,500	124	12	
13	32	INTEREST (WORKING CAP)	DIRECT COST	2	3,375	0	1	1,688	13	
14	20	RECRUITMENT	GROSS REVENUE	5	1,090	0	2,088,500	224	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 367,505	\$ 252,137		\$ 102,518	25	

Facility Name & ID Number **PLEASANT VIEW**# **0042416**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00**

## 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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	MORTGAGE SEE SCH VII B		X	MORTGAGE	\$11,591.00		\$	\$ 1,525,618		8.35%	\$ 104,233	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6	FIRST IL NATIONAL BANK		X	WORKING CAPITAL	\$7,644.00			405,627		9.50 & 8.35	43,647	6								
7	CORPORATE ALLOCATION	X		WORKING CAPITAL			25,000	25,000		9.0000	1,812	7								
8	OSO PARTNERS	X		WORKING CAPITAL	\$1,636.00		167,400	140,808	01/01/12	8.38%	12,087	8								
9	TOTAL Facility Related				\$20,871.00		\$ 192,400	\$ 2,097,053			\$ 161,779	9								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 192,400	\$ 2,097,053			\$ 161,779	15								

\* 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.)



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,743 B. General Construction Type: Exterior BRICK Frame METAL Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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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	<u>FACILITY GROUNDS</u>		<u>1996</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>			<u>\$ 50,000</u>	<u>3</u>

Facility Name &amp; ID Number PLEASANT VIEW

# 0042416

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74		1996	1996	\$ 1,200,000	\$ 30,768	39	\$ 30,768		\$ 123,072	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		BOOSTER HEATER	1997	1997	1,582	79	20	79		316	9
10		GARAGE/STORAGE	1997	1997	1,670	84	20	84		335	10
11		BULTIN WHIRLPOOL BATHING SYSTEMS	1997	1997	22,217	2,222	10	2,222		8,183	11
12		CIRCULATING PUMP	1997	1997	1,353	135	10	135		473	12
13		FLOOR TILE	1997	1997	1,430	95	15	95		357	13
14		REMODEL OFFICE	1997	1997	8,092	809	10	809		2,832	14
15		FURNACES	1997	1997	16,130	1,075	15	1,075		3,942	15
16		ROOM SIGNAGE	1997	1997	1,666	167	10	167		584	16
17		PAINTING	1997	1997	12,962	1,852	7	1,852		6,482	17
18		LOCKS & PLATE FLAQUES	1997	1997	820	82	10	82		287	18
19		WINDOW TREATMENTS	1997	1997	772	154	5	154		539	19
20		WINDOW TREATMENTS	1997	1997	5,228	523	10	523		1,830	20
21		DOOR ALARM SYSTEM	1997	1997	12,550	1,255	10	1,255		4,392	21
22		LANDSCAPING	1997	1997	13,055	1,306	10	1,306		4,570	22
23		SEALING PARKING LOT	1997	1997	2,926	585	5	585		2,048	23
24		OFFICE REMODELING(ADDT')	1998	1998	6,367	910	7	910		2,654	24
25		BEAUTY SHOP REMODELING	1998	1998	6,844	342	20	342		941	25
26		AIR CONDITIONING/HEATING UNITS	1998	1998	6,332	422	15	422		914	26
27		SPRINKLER SYSTEM	1999	1999	10,944	730	15	730		1,399	27
28		POLYVINYL FENCING	1999	1999	2,133	142	15	142		225	28
29		GAZEBO	1999	1999	7,383	492	15	492		738	29
30		REMODEL DINING ROOM	1999	1999	20,459	1,023	20	1,023		1,108	30
31		INSTALL LIGHTS& CEILING FANS(NURSING STATION	2000	2000	989	45	20	45		45	31
32		65 GALLON WATER HEATER	2000	2000	4,696	235	10	235		235	32
33		PLANTER INSTALLATION	2000	2000	3,280	164	10	164		164	33
34											34
35											35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 1,371,880	\$ 45,696		\$ 45,696		\$ 168,665	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.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 357,487	\$ 40,779	\$ 50,739	\$ 9,960	VARIOUS	\$ 171,146	37
38	Current Year Purchases	24,470	1,970	1,970		VARIOUS	1,970	38
39	Fully Depreciated Assets							39
40	HOME OFFICE ALLOCATION		994	994				40
41	TOTALS	\$ 381,957	\$ 43,743	\$ 53,703	\$ 9,960		\$ 173,116	41

D. Vehicle Depreciation (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	
42	HOME OFFICE ALLOCATION			\$	\$ 1,639	\$ 1,639	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$ 1,639	\$ 1,639	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,803,837	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 91,078	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 101,038	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 9,960	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 341,781	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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: OSO PARTNERS  
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>74</u>	<u>01/01/98</u>	\$ <u>155,697</u>	<u>5</u>	<u>15</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>74</b>		\$ <b>155,697</b>			7

10. Effective dates of current rental agreement:  
 Beginning 01/01/98  
 Ending 12/31/02

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2001</u>	\$ <u>155,697</u>
13.	<u>12/31/2002</u>	\$ <u>155,697</u>
14.	<u>12/31/2003</u>	\$ <u>155,697</u>

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: 2002,\$1325000 \*

**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	<u>TRANSPORTATION</u>	<u>1996 VAN</u>	\$ <u>500.00</u>	\$ <u>6,000</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>500.00</b>	\$ <b>6,000</b>	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.

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>96</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>48</u></p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies			96	96
3 Classroom Wages (a)	2,369	7,438		9,807
4 Clinical Wages (b)		3,722		3,722
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments			4,782	4,782
8 Nurse Aide Competency Tests				
9 TOTALS	\$ 2,369	\$ 11,160	\$ 4,878	\$ 18,407
10 SUM OF line 9, col. 1 and 2 (e)	\$ 13,529			

- (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 aide 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 aides.

**C. CONTRACTUAL INCOME**

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

\$ NONE

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>16</b>

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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		hrs							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	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number PLEASANT VIEW

# 0042416

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,932	\$ 4,459	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000 )	226,094	424,012	3
4	Supply Inventory (priced at COST )	31,045	76,756	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,585	24,585	6
7	Other Prepaid Expenses	355	355	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED		100,790	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 287,011	\$ 630,957	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		4,292	11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	171,880	913,683	15
16	Equipment, at Historical Cost	147,357	766,959	16
17	Accumulated Depreciation (book methods)	(84,653)	(860,465)	17
18	Deferred Charges	123,738	123,738	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 358,322	\$ 948,207	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 645,333	\$ 1,579,164	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 114,542	\$ 470,760	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	58,224	68,604	29
30	Accrued Salaries Payable	24,351	55,143	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,956	31,231	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,820	45,487	32
33	Accrued Interest Payable	3,469	12,652	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	OTHER SEE ATTACHED	(6,037)	(10,075)	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 245,325	\$ 673,802	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	355,287	435,590	39
40	Mortgage Payable	132,924	330,313	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43			3,006	43
44	OTHER SEE ATTACHED	220,941	223,076	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 709,152	\$ 991,985	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 954,477	\$ 1,665,787	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (309,144)	\$ (86,623)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 645,333	\$ 1,579,164	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (300,495)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (300,495)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(8,649)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (8,649)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (309,144)	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,098,071	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,092,071	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,885	6
7	Oxygen	12,701	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 23,586	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,792	11
12	Gift and Coffee Shop	224	12
13	Barber and Beauty Care	581	13
14	Non-Patient Meals	2,967	14
15	Telephone, Television and Radio	2,975	15
16	Rental of Facility Space		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 12,539	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION</b>	921	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 921	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,129,117	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	556,451	31
32	Health Care	854,218	32
33	General Administration	386,979	33
<b>B. Capital Expense</b>			
34	Ownership	294,671	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,821	35
36	Provider Participation Fee	40,626	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,137,766	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(8,649)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (8,649)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

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

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

Facility Name &amp; ID Number PLEASANT VIEW

# 0042416

Report Period Beginning: 01/01/00

Ending:

12/31/00

## 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	1,933	\$ 45,291	\$ 21.35	1
2	Assistant Director of Nursing				2
3	Registered Nurses	10,846	168,943	14.61	3
4	Licensed Practical Nurses	7,114	90,529	11.60	4
5	Nurse Aides & Orderlies	39,444	340,506	8.06	5
6	Nurse Aide Trainees	1,913	13,529	7.07	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,811	23,632	12.06	9
10	Activity Assistants	1,908	21,915	10.50	10
11	Social Service Workers	4,055	49,320	11.44	11
12	Dietician				12
13	Food Service Supervisor	1,974	22,042	10.29	13
14	Head Cook				14
15	Cook Helpers/Assistants	18,402	125,226	6.43	15
16	Dishwashers				16
17	Maintenance Workers	4,425	46,234	9.85	17
18	Housekeepers	8,308	48,726	5.54	18
19	Laundry	6,433	38,918	5.73	19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	1,880	21,884	10.48	23
24	Clerical	1,759	12,810	6.73	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	921	9,176	9.21	31
32	Other Health Care(specify)				32
33	Other(specify) <u>PHY THERAPY</u>	1,854	22,566	9.55	33
34	TOTAL (lines 1 - 33)	114,980	\$ 1,101,247 *	\$ 8.94	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	113	\$ 4,520	1/3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	16	814	10/3	39
40	Physical Therapy Consultant	36	1,813	10a/3	40
41	Occupational Therapy Consultant	9	450	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	400	10a/3	43
44	Activity Consultant				44
45	Social Service Consultant	12	629	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	196	\$ 8,626		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	Nurse Aides	103	1,035	10/3	52
53	TOTAL (lines 50 - 52)	103	\$ 1,035		53





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. ILLINOIS HEALTH CARE ASSOC. \$3198
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,635 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (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 of Public Aid during this cost report period. \$ 40,626  
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,967
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? \_\_\_\_\_  
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? 100%  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ NONE**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.