

		FOR BHF USE				

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0042416

Facility Name: PLEASANT VIEW

Address: 500 NORTH JACKSON STREET MORRISON 61270
 Number City Zip Code

County: WHITESIDE

Telephone Number: 815-772-7288 **Fax #** 815-772-2399

HFS ID Number: 36-2819435003

Date of Initial License for Current Owners: 12/6/96

Type of Ownership:

<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
IRS Exemption Code _____	<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 _____	

In the event there are further questions about this report, please contact:
Name: DAVE HECKMAN **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JOHN SMITH</u>	
	(Title) <u>CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number PLEASANT VIEW# 0042416 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 9/1/2004

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>8</u>	Skilled (SNF)	<u>8</u>	<u>2,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>66</u>	Intermediate (ICF)	<u>66</u>	<u>24,090</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		<u>22</u>	<u>699</u>	<u>721</u>	8
9	SNF/PED					9
10	ICF	<u>14,581</u>	<u>6,387</u>		<u>20,968</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,581</u>	<u>6,409</u>	<u>699</u>	<u>21,689</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.30%

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

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)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 12/6/96

J. 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 8 and days of care provided 699Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/06 Ending: 12/31/06

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
	A. General Services										
1	Dietary	180,607	17,785	7,050	205,442		205,442		205,442		1
2	Food Purchase		142,018		142,018		142,018	(3,938)	138,080		2
3	Housekeeping	53,088	16,548		69,636		69,636		69,636		3
4	Laundry	32,823	18,850		51,673		51,673		51,673		4
5	Heat and Other Utilities			83,366	83,366		83,366	(5,738)	77,628		5
6	Maintenance	61,264	22,236	17,281	100,781	89	100,870	278	101,148		6
7	Other (specify):*										7
8	TOTAL General Services	327,782	217,437	107,697	652,916	89	653,005	(9,398)	643,607		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	861,982	116,144	10,111	988,237	(10,496)	977,741	(11,122)	966,619		10
10a	Therapy	19,706		54,183	73,889		73,889		73,889		10a
11	Activities	52,705	7,140	880	60,725		60,725		60,725		11
12	Social Services	43,158			43,158		43,158		43,158		12
13	CNA Training	9,155		5,330	14,485		14,485		14,485		13
14	Program Transportation	11,329	3,558		14,887	(3,558)	11,329		11,329		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	998,035	126,842	73,504	1,198,381	(14,054)	1,184,327	(11,122)	1,173,205		16
	C. General Administration										
17	Administrative			130,219	130,219		130,219	(36,478)	93,741		17
18	Directors Fees										18
19	Professional Services			18,835	18,835		18,835	641	19,476		19
20	Dues, Fees, Subscriptions & Promotions			38,903	38,903		38,903	(23,968)	14,935		20
21	Clerical & General Office Expenses	44,067	11,604	11,553	67,224		67,224	2,004	69,228		21
22	Employee Benefits & Payroll Taxes			204,928	204,928	(1,227)	203,701	14,103	217,804		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,012	6,012		6,012		6,012		24
25	Other Admin. Staff Transportation							775	775		25
26	Insurance-Prop.Liab.Malpractice			32,769	32,769		32,769	448	33,217		26
27	Other (specify):* SALES TAX			834	834		834	(834)			27
28	TOTAL General Administration	44,067	11,604	444,053	499,724	(1,227)	498,497	(43,309)	455,188		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,369,884	355,883	625,254	2,351,021	(15,192)	2,335,829	(63,829)	2,272,000		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 & ID Number PLEASANT VIEW

#0042416

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	
	D. Ownership											
30	Depreciation			54,508	54,508	(89)	54,419	31,767	86,186			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,612	38,612		38,612	72,074	110,686			32
33	Real Estate Taxes			40,253	40,253		40,253		40,253			33
34	Rent-Facility & Grounds			155,698	155,698		155,698	(155,697)	1			34
35	Rent-Equipment & Vehicles			6,000	6,000	(6,000)						35
36	Other (specify):* GOODWILL			11,316	11,316		11,316	(11,316)				36
37	TOTAL Ownership			306,387	306,387	(6,089)	300,298	(63,172)	237,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					9,558	9,558		9,558			38
39	Ancillary Service Centers					6,157	6,157		6,157			39
40	Barber and Beauty Shops					5,566	5,566		5,566			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			40,515	40,515	21,281	61,796		61,796			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,369,884	355,883	972,156	2,697,923		2,697,923	(127,001)	2,570,922			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: 1/1/06

Ending: 12/31/06

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	(3,938)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,738)	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
10	Interest and Other Investment Income	(2,452)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(834)	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	(500)	20		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	(19,473)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,559)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(23,096)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,590)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(67,411)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,411)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (127,001)		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		\$ 9,558	14,35	38
39	PA OXYGEN	X		6,157	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops	X		5,566	10	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	TOTAL (C): (sum of lines 38-46)			\$ 21,281		47

BHF USE ONLY						
48		49		50		52

PLEASANT VIEW

ID# 0042416

Report Period Beginning: 1/1/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	FLOWERS	\$ (658)	20	1
2	GOODWILL	(11,316)	36	2
3	EMPLOYEES AT OTHER FACILITIES	(11,122)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(23,096)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

1/1/06

Ending:

12/31/06

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,938)	0	0	0	0	0	0	0	0	0	0	(3,938)	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	(5,738)	0	0	0	0	0	0	0	0	0	0	(5,738)	5
6	Maintenance	0	0	278	0	0	0	0	0	0	0	0	278	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,676)	0	278	0	(9,398)	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	(11,122)	0	0	0	0	0	0	0	0	0	0	(11,122)	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	(11,122)	0	0	0	0	0	0	0	0	0	0	(11,122)	16
	C. General Administration													
17	Administrative	0	0	(36,478)	0	0	0	0	0	0	0	0	(36,478)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	360	281	0	0	0	0	0	0	0	0	641	19
20	Fees, Subscriptions & Promotions	(24,190)	0	222	0	0	0	0	0	0	0	0	(23,968)	20
21	Clerical & General Office Expenses	0	0	2,004	0	0	0	0	0	0	0	0	2,004	21
22	Employee Benefits & Payroll Taxes	0	0	14,103	0	0	0	0	0	0	0	0	14,103	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	775	0	0	0	0	0	0	0	0	775	25
26	Insurance-Prop.Liab.Malpractice	0	0	448	0	0	0	0	0	0	0	0	448	26
27	Other (specify):*	(834)	0	0	0	0	0	0	0	0	0	0	(834)	27
28	TOTAL General Administration	(25,024)	360	(18,645)	0	(43,309)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,822)	360	(18,367)	0	(63,829)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT VIEW

0042416 Report Period Beginning:

1/1/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	30,769	998	0	0	0	0	0	0	0	0	31,767	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,452)	73,475	1,051	0	0	0	0	0	0	0	0	72,074	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(155,697)	0	0	0	0	0	0	0	0	0	(155,697)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(11,316)	0	0	0	0	0	0	0	0	0	0	(11,316)	36
37	TOTAL Ownership	(13,768)	(51,453)	2,049	0	(63,172)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(59,590)	(51,093)	(16,318)	0	(127,001)	45							

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

1/1/06

Ending:

12/31/06

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
<u>BIG MEADOWS, INC.</u>	<u>100%</u>	<u>BIG MEADOWS</u>	<u>SAVANNA</u>	<u>OSO PARTNERS</u>	<u>MARION, IOWA</u>	<u>BLDG. RENTAL</u>
<u>AMERICAN HEALTH ENTERPRISES, INC</u>	<u>100%</u>					
<u>ALAN GAPINSKI</u>	<u>100%</u>	<u>WINNING WHEELS, INC.</u>	<u>PROPHETSTOWN</u>			
	<u>0%</u>	<u>S.T.R.I.V.E.</u>	<u>PROPHETSTOWN</u>			
	<u>0%</u>					

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)	
<u>1</u>	<u>V</u>	<u>34 RENT</u>	<u>\$ 155,697</u>	<u>OSO PARTNERS - BUILDING OWNER</u>	<u>100.00%</u>	<u>\$</u>	<u>\$(155,697)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>30 DEPRECIATION</u>				<u>30,769</u>	<u>30,769</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>32 MORTGAGE INTEREST</u>				<u>73,475</u>	<u>73,475</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>19 PROFESSIONAL SERVICES</u>				<u>360</u>	<u>360</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>VAR SEE ATTACHED PAGE 6A</u>	<u>130,219</u>	<u>AMERICAN HEALTH ENTERPRISES, INC.</u>	<u>100.00%</u>	<u>113,901</u>	<u>\$(16,318)</u>	<u>5</u>
<u>6</u>	<u>V</u>							<u>6</u>
<u>7</u>	<u>V</u>							<u>7</u>
<u>8</u>	<u>V</u>							<u>8</u>
<u>9</u>	<u>V</u>							<u>9</u>
<u>10</u>	<u>V</u>							<u>10</u>
<u>11</u>	<u>V</u>							<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	Total		\$ 285,916			\$ 218,505	\$ * (67,411)	14

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

VII. RELATED PARTIES (continued)

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)	
15	V	17 MAAGEMENT FEES	\$ 130,219	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$	(130,219)	15
16	V	17 (SEE PAGE 8)		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	93,741	93,741	16
17	V	19		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	281	281	17
18	V	20		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	222	222	18
19	V	21		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	2,004	2,004	19
20	V	22		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	14,103	14,103	20
21	V	24		AMERICAN HEALTH ENTERPRISES, INC.	100.00%			21
22	V	25		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	775	775	22
23	V	26		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	448	448	23
24	V	30		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	998	998	24
25	V	32		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,051	1,051	25
26	V	6		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	278	278	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 130,219			\$ 113,901	\$ * (16,318)	39

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

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 Enterprises, Inc			100.00					\$	1
2	Alan Gapinski	President	Direct Managemenr							2
3										3
4	Big Meadows			100.00	36,792	10	28.00	management fees	155,934	4
5	Pleasant View			100.00	26,280	10	28.00	"	130,219	5
6	Winning Wheels			NONE	47,304	18	36.00	"	177,500	6
7	S.T.R.I.V.E.			NONE	13,140	5	10.00	"	109,750	7
8	Other(non cost reporting)			NONE	7,884	3	6.00	"	136,012	8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 709,415	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:

1/1/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Admin	Direct	1	\$ 51,440	\$	1	\$ 51,440	1
2	17	Admin	Gross Revenue	12,009,091	5	207,409	2,449,265	42,301	2
3	19	Data Processing	Gross Revenue	12,009,091	5	1,311	2,449,265	267	3
4	19	Accounting	Gross Revenue	12,009,091	5	68	2,449,265	14	4
5	20	Due, fees	Gross Revenue	12,009,091	5	1,090	2,449,265	222	5
6	21	Supplies, telephone	Gross Revenue	12,009,091	5	9,828	2,449,265	2,004	6
7	22	Benefits	% of salary	454,180	5	68,329	93,741	14,103	7
8	24	Training Seminars	Gross Revenue	12,009,091	5	0	2,449,265	0	8
9	25	Admin Transport	Gross Revenue	12,009,091	5	3,798	2,449,265	775	9
10	26	Insurance	Gross Revenue	12,009,091	5	2,199	2,449,265	448	10
11	30	Depreciation	Gross Revenue	12,009,091	5	4,895	2,449,265	998	11
12	32	Interest Vehicles	Gross Revenue	12,009,091	5	1,358	2,449,265	277	12
13	32	Interst W/C	Direct	2	1,548		1	774	13
14	6	Maint Supplies	Gross Revenue	12,009,091	5	1,362	2,449,265	278	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 354,635	\$		\$ 113,901	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	MORTGAGE-SEE SCH. VIIB		X	MORTGAGE	\$11,591.00	12/1/96	\$ 1,350,000	\$	4/6/2006	7.5000	\$ 73,475	1								
2	AMCORE BANK		X	CORPORATE VEHICLE	\$1,003.00	9/2006	32,000		9/2009	6.5000	277	2								
3												3								
4												4								
5												5								
Working Capital																				
6	THE NATIONAL BANK		X	WORKING CAPITAL	\$3,122.73	6/9/2004		57,150	6/9/2009	7.0000	32,471	6								
7	OSO PARTNERS	X		WORKING CAPITAL	\$1,636.21	12/8/96	167,700	70,856	12/8/2010	6.7500	6,141	7								
8	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	25,000		7/2010	5.0000	774	8								
9	TOTAL Facility Related				\$17,352.94		\$ 1,574,700	\$ 128,006			\$ 113,138	9								
B. Non-Facility Related*																				
10	INTEREST INCOME OFFSET		X								(2,452)	10								
11	(SCHEDULE VI, PAGE 5)											11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(2,452)	14								
15	TOTALS (line 9+line14)						\$ 1,574,700	\$ 128,006			\$ 110,686	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line #

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT VIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0042416

CONTACT PERSON REGARDING THIS REPORT DAVE HECKMAN

TELEPHONE 815-778-3683 FAX #: 815-778-4503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-17-130-001</u>	<u>PT NW SEC 17 TWP 21 RNG 5</u>	\$ <u>38,657.64</u>	\$ <u>38,657.64</u>
2. _____	<u>MF 10831-96 28603x</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,657.64</u>	\$ <u>38,657.64</u>

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? YES X NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number PLEASANT VIEW

0042416 Report Period Beginning:

1/1/06 Ending:

12/31/06

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: _____ 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>	1
2					2
3	TOTALS			\$ 50,000	3

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1996	1974	\$ 1,200,000	\$	39	\$ 30,769	\$ 30,769	\$ 307,592	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		WATER HEATER	1997	1997	1,582	79	20	79		791	9
10		GARAGE/STORAGE	1997	1997	1,670	84	20	84		835	10
11		BUILT-IN WHIRLPOOL BATHING SYSTEM	1997	1997	22,217	2,222	10	2,222		21,513	11
12		CIRCULATING PUMP	1997	1997	1,353		10			1,353	12
13		FLOOR TILE	1997	1997	1,430	95	151	95		930	13
14		REMODEL OFFICES	1997	1997	8,092	809	10	809		7,688	14
15		FURNACES	1997	1997	16,130	1,075	15	1,075		10,395	15
16		ROOM SIGNAGE	1997	1997	1,666	167	10	167		1,583	16
17		PAINTING	1997	1997	12,962		7			12,962	17
18		LOCKS & PLATE PLAQUES	1997	1997	820	82	10	82		779	18
19		WINDOW TREATMENTS	1997	1997	772		5			772	19
20		WINDOW TREATMENTS	1997	1997	5,228	523	10	523		4,967	20
21		DOOR ALARM SYSTEMS	1997	1997	12,550	1,255	10	1,255		11,923	21
22		LANDSCAPING	1997	1997	13,055	1,306	10	1,306		12,403	22
23		SEAL PARKING LOT	1997	1997	2,926		5			2,926	23
24		OFFICE REMODELING (ADDT'L)	1998	1998	6,367		7			6,367	24
25		BEAUTY SHOP REMODELING	1998	1998	6,844	342	20	342		2,994	25
26		AIR CONDITIONING/HEATING UNITS	1998	1998	6,332	422	15	422		3,447	26
27		SPRINKLER SYSTEM	1999	1999	10,944	730	15	730		5,776	27
28		POLYVINYL FENCING	1999	1999	2,133	142	15	142		1,078	28
29		GAZEBO	1999	1999	7,383	492	15	492		3,692	29
30		REMODEL DINING ROOM	1999	1999	20,459	1,023	20	1,023		7,246	30
31		INSTALL LIGHTS & CEILING FANS (NURSE STATION)	2000	2000	989	49	20	49		342	31
32		65 GALLON WATER HEATER	2000	2000	4,696	470	10	470		3,052	32
33		PLANTER INSTALLATION	2000	2000	3,280	328	10	328		2,132	33
34		KITCHEN REMODELING	2001	2001	13,860	924	15	924		5,544	34
35		AWNING	2001	2001	2,504	250	10	250		1,377	35
36											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

0042416

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CHANGE A/C COMPRESSOR	2001	\$ 2,268	\$ 227	10	\$ 227	\$	\$ 1,247	37
38	REMODEL LAUNDRY ROOM	2001	4,714	121	39	121		635	38
39	HEAT TAPE CUTTERS	2001	1,603	160	10	160		882	39
40	CEILING, TILE, LIGHTS & INSTALLATION	2002	13,327	888	15	888		4,442	40
41	LAUNDRY ROOM FLOOR TILE	2002	1,125	75	15	75		375	41
42	COMMERCIAL DISPOSAL	2002	951	95	10	95		428	42
43	LAUNDRY ROOM A/C	2002	3,086	309	10	309		1,388	43
44	REPLACE ROOF	2002	47,430	2,372	20	2,372		10,079	44
45	SHUTTERS	2002	852	57	15	57		232	45
46	REMODEL HALLWAY	2003	26,281	2,628	10	2,628		9,198	46
47	MAIN STREET PROJECT	2004	25,169	3,596	7	3,596		8,989	47
48	PHYSICAL THERAPY WALKING AREA	2004	18,427	1,843	10	1,843		4,607	48
49	DECK	2004	8,535	853	10	853		2,134	49
50	GENERATOR	2004	59,537	2,381	25	2,381		6,351	50
51	SECURITY CAMERA	2004	1,519	217	7	217		542	51
52	ROOM WINDOWS	2005	1,448	72	20	72		115	52
53									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)		\$ 1,604,516	\$ 28,763		\$ 59,532	\$ 30,769	\$ 494,100	70

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

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	
71	Purchased in Prior Years	\$ 205,379	\$ 25,255	\$ 25,255	\$	VARIOUS	\$ 209,754	71
72	Current Year Purchases	5,372	401	401		VARIOUS	401	72
73	Fully Depreciated Assets	40,825				VARIOUS	40,825	73
74								74
75	TOTALS	\$ 251,576	\$ 25,655	\$ 25,655	\$		\$ 250,980	75

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	
76	HOME OFFICE ALLOCATION			\$	\$	998	998		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	998	998		\$	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	1,906,092	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	54,418	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	86,185	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	31,767	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	745,080	85

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

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

G. Construction-in-Progress

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

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

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

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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>74</u>	<u>1/1/2003</u>	\$ <u>155,697</u>	<u>5</u>	<u>13</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		74		\$ 155,697			7

10. Effective dates of current rental agreement:

Beginning 1/1/2003

Ending 12/31/07

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2007</u>	\$ <u>155,697</u>
13.	<u>12/31/2008</u>	\$ <u>155,697</u>
14.	<u>12/31/2009</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: _____ *

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>2005 FORD VAN</u>	\$ <u>500.00</u>	\$ <u>6,000</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 500.00	\$ 6,000	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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. CLASSROOM PORTION:</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 CNA <u>96</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		3,456		3,456
4	Clinical Wages (b)		5,699		5,699
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		5,330		5,330
8	CNA Competency Tests				
9	TOTALS	\$	\$ 14,485	\$	\$ 14,485
10	SUM OF line 9, col. 1 and 2 (e)	\$	14,485		

C. CONTRACTUAL INCOME

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

\$ NONE

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>9</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

- (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.

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	10a,3	151 hrs	\$ 13,541		\$	\$	151	\$ 13,541	1
2	Licensed Speech and Language Development Therapist	10a,3	32 hrs	2,913				32	2,913	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	422 hrs	37,730				422	37,730	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			\$ 54,183		\$	\$	605	\$ 54,183	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.

Facility Name & ID Number PLEASANT VIEW# 0042416Report Period Beginning: 1/1/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (252,001)	\$ 85,949	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>447293-26821</u>)	420,472	840,426	3
4	Supply Inventory (priced at <u>COST</u>)	34,517	78,743	4
5	Short-Term Investments			5
6	Prepaid Insurance	16,071	24,000	6
7	Other Prepaid Expenses	4,733	10,287	7
8	Accounts Receivable (owners or related parties)		4,514	8
9	Other(specify):		37,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 223,792	\$ 1,080,919	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,950	30,100	12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	404,516	430,984	15
16	Equipment, at Historical Cost	251,576	975,895	16
17	Accumulated Depreciation (book methods)	(377,208)	(1,019,097)	17
18	Deferred Charges			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): <u>GOODWILL</u>	55,842	55,842	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 347,676	\$ 473,724	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 571,468	\$ 1,554,643	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 154,764	\$ 429,819	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,269	206,417	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,253	13,470	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,658	82,083	32
33	Accrued Interest Payable	1,971	29,944	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO BIG MEADOWS, INC.</u>	767,434		36
37	<u>RESIDENT S.S. PAYABLE</u>	659	1,034	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,059,007	\$ 762,768	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	128,006	691,384	39
40	Mortgage Payable		197,389	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>RENTS PAYABLE-OSO PARTNERS</u>	347,821	347,821	43
44	<u>DUE TO AHE, INC.</u>	100,507	347,347	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 576,334	\$ 1,583,942	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,635,340	\$ 2,346,709	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,063,871)	\$ (792,065)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 571,469	\$ 1,554,644	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (815,214)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (815,214)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(248,657)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (248,657)	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)	\$ (1,063,871)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning: 1/1/06

Ending: 12/31/06

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,377,446	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,371,446	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	37,937	6
7	Oxygen	2,905	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 40,843	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,467	11
12	Gift and Coffee Shop	79	12
13	Barber and Beauty Care	6,933	13
14	Non-Patient Meals	3,938	14
15	Telephone, Television and Radio	5,738	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,155	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,452	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,452	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	3,248	28
28a	EMPLOYEES @ OTHER LOCATIONS	11,122	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,370	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,449,266	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	652,916	31
32	Health Care	1,198,381	32
33	General Administration	499,724	33
B. Capital Expense			
34	Ownership	306,387	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,697,923	40
41	Income before Income Taxes (line 30 minus line 40)**	(248,657)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (248,657)	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 & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	1,691	1,852	\$ 45,219	\$ 24.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,666	7,023	150,331	21.41	3
4	Licensed Practical Nurses	12,398	13,221	236,258	17.87	4
5	CNAs & Orderlies	40,173	44,306	413,814	9.34	5
6	CNA Trainees	1,138	1,138	9,155	8.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	819	819	19,706	24.06	8
9	Activity Director	1,892	1,955	24,294	12.43	9
10	Activity Assistants	2,435	2,528	28,411	11.24	10
11	Social Service Workers	2,844	3,114	43,158	13.86	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,144	26,934	12.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,792	19,958	153,673	7.70	15
16	Dishwashers					16
17	Maintenance Workers	4,621	5,026	61,264	12.19	17
18	Housekeepers	5,947	6,238	53,088	8.51	18
19	Laundry	4,172	4,371	32,823	7.51	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,881	2,101	26,565	12.64	23
24	Clerical	1,938	2,089	17,502	8.38	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	1,311	1,443	16,360	11.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>TRANSPORTATI</u>	969	1,019	11,329	11.12	33
34	TOTAL (lines 1 - 33)	111,615	120,345	\$ 1,369,884 *	\$ 11.38	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	157	\$ 7,050	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	18	720	10,3	39
40	Physical Therapy Consultant	422	37,730	10a,3	40
41	Occupational Therapy Consultant	151	13,541	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	32	2,913	10a,3	43
44	Activity Consultant	22	880	11,3	44
45	Social Service Consultant				45
46	Other(specify) <u>LAB</u>	4	1,847	10,3	46
47	<u>MOBILE X-RAY</u>	5	667	10,3	47
48	<u>WINNING WHEELS THERAPISTS</u>	199	6,877	10,3	48
49	TOTAL (lines 35 - 48)	1,040	\$ 75,223		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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINTING		\$ 899	5	\$ 180	\$ 180	\$ 180	\$ 89	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 899		\$ 180	\$ 180	\$ 180	\$ 89	\$	\$	\$	\$	\$

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-\$4236
- (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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,078 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 during this cost report period. \$ 40,515
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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.