

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 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 1/1/07 to 12/31/07 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: 1/1/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	8	Skilled (SNF)	8	2,920	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			832	832	8
9	SNF/PED					9
10	ICF	13,708	5,481		19,189	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,708	5,481	832	20,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.12%

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 _____

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

**Income Statement
For Month To Ending 12/31/2027**

OPERATIONS

Planned View (PLN)

Account	Description	Planned		Diff. Percent
		01	02	
REVENUE				
4000 01	PUBLIC AD	\$1,348,247.00	\$1,348,247.00	
4000 02	PHYSICIAN FEE	\$1,028,000.00	\$1,028,000.00	
4000 03	SUPPLIES	\$1,500.00	\$11,800.00	
4000 04	MEDICARE PART A - THERAPY	\$0.00	\$0.00	
4000 05	PHYSICAL THERAPY	\$3,800.00	\$3,800.00	
4000 06	RECEIPTS	\$2,000.00	\$2,000.00	
4000 07	MEDICARE PART A - SUPPLIES	\$3,000.00	\$3,000.00	
4100 01	OFFICE	\$2,000.00	\$2,000.00	
4100 02	MEDICARE A	\$26,481.00	\$26,481.00	42.3
4200 01	ASSISTANT FIELD - P. A.	\$62,000.00	\$62,000.00	
4300 01	BAD DEBTS	\$0.00	\$0.00	
Total Revenue		\$2,445,528.00	\$2,479,528.00	
OPERATIONAL				
4300 01	TRANSPORTATION	\$1,200.00	\$1,200.00	
4300 02	DATA TRANSMISSION/REPRODUCTION	\$4,000.00	\$4,000.00	
4300 03	CABLE TV	\$3,000.00	\$3,000.00	
4300 04	MAIL	\$4,500.00	\$4,500.00	
4300 05	WARRANTY/REPAIRS	\$0.00	\$0.00	
4300 06	PHYSICAL FACILITY TRS	\$1,500.00	\$1,500.00	
4300 07	EMPLOYEES AT OTHER FACILITIES	\$100.00	\$100.00	
4300 08	RENT/LEASES	\$2,000.00	\$2,000.00	
Total Operational		\$12,700.00	\$12,700.00	
PERSONNEL				
4400 01	NURSING ADMIN	\$18,000.00	\$0.00	10.1
4400 02	NURSES	\$403,000.00	\$390,000.00	10.1
4400 03	PHYSICIAN	\$400,000.00	\$400,000.00	
4400 04	PHYSICAL THERAPY	\$3,000.00	\$3,000.00	101.1
4400 05	OCUPATIONAL THERAPY	\$2,000.00	\$2,000.00	
4400 06	RECREATIONAL THERAPY	\$4,000.00	\$4,000.00	1.1
4400 07	SOCIAL SERVICES	\$4,000.00	\$4,000.00	1.1
4400 08	SPEECH THERAPY	\$300.00	\$0.00	101.1
Total Personnel		\$834,700.00	\$807,000.00	
NON-CLINICAL SERVICES				
4500 01	MEDICAL RECORDS	\$14,700.00	\$1,700.00	10.1
4500 02	DIETARY	\$10,000.00	\$0.00	1.1
4500 03	HOUSEKEEPING	\$60,000.00	\$0.00	3.1
4500 04	LAUNDRY	\$0.00	\$0.00	4.1
4500 05	MAINTENANCE	\$60,000.00	\$0.00	6.1
4500 06	TRANSPORTATION	\$11,000.00	\$1,000.00	14.1
4500 07	ADMINISTRATION	\$0.00	\$0.00	21.1
Total Non-Clinical Services		\$145,700.00	\$1,700.00	
EXPENSES				
4600 01	FOOD	\$10,000.00	\$0.00	22.3
4600 02	EXPENSES COMP	\$4,700.00	\$4,700.00	22.3
4600 03	LABORATORY	\$4,000.00	\$4,000.00	
4600 04	DIAGNOSTIC	\$15,100.00	\$1,100.00	22.3
4600 05	LABORATORY	\$2,000.00	\$2,000.00	
4600 06	HEALTH INSURANCE	\$14,000.00	\$14,000.00	22.3
4600 07	DEBTS PAYABLE	\$1,700.00	\$1,700.00	22.3
4600 08	PHYSICALS	\$400.00	\$400.00	
4600 09	LABORERS	\$0.00	\$0.00	22.3
4600 10	PROFESSIONAL LICENSES FEE	\$0.00	\$0.00	22.3
4600 11	OTHER	\$4,000.00	\$4,000.00	
Total Expenses		\$107,800.00	\$107,800.00	
CONTRACT CLINICAL SERVICES				
4700 01	PHYSICIAN	\$14,000.00	\$4,000.00	9.3
4700 02	PHYSICIAN/REGISTERED NURSES	\$0.00	\$0.00	10.3
4700 03	PHYSICAL THERAPY	\$0.00	\$0.00	10.3
4700 04	OCUPATIONAL THERAPY	\$1,000.00	\$1,000.00	11.3
4700 05	MUSIC THERAPY	\$1,000.00	\$1,000.00	11.3
4700 06	SOCIAL SERVICES	\$1,000.00	\$1,000.00	10.3
4700 07	ART THERAPY	\$0.00	\$0.00	10.3
4700 08	YOGA	\$0.00	\$0.00	10.3
4700 09	DRUG MEDICATION PART A	\$2,000.00	\$2,000.00	10.3
4700 10	X-RAY MEDICARE A	\$2,000.00	\$2,000.00	10.3
Total Contract Clinical Services		\$12,000.00	\$12,000.00	
CONTRACT NON-CLINICAL SERVICES				
4800 01	DIETARY	\$7,000.00	\$7,000.00	1.3
4800 02	HOUSEKEEPING	\$0.00	\$0.00	11.3
4800 03	DATA PROCESSING	\$1,000.00	\$1,000.00	15.3
Total Contract Non-Clinical Services		\$8,000.00	\$8,000.00	
SUPPLIES				
4900 01	NURSING	\$4,000.00	\$4,000.00	10.2
4900 02	OFFICE	\$4,000.00	\$4,000.00	10.2
4900 03	OFFENSES/MAINT	\$0.00	\$0.00	10.2
4900 04	PHYSICIAN THERAPY	\$4,000.00	\$4,000.00	11.2
4900 05	PT & OT	\$0.00	\$0.00	11.2
4900 06	PHARMACY	\$1,000.00	\$1,000.00	10.2
4900 07	PHARMACY - MEDICARE PART A	\$0.00	\$0.00	10.2
4900 08	DIETARY	\$1,000.00	\$1,000.00	1.2
4900 09	FOOD	\$0.00	\$0.00	2.2
4900 10	HOUSEKEEPING	\$1,000.00	\$1,000.00	3.2
4900 11	LAUNDRY	\$0.00	\$0.00	4.2
4900 12	MAINTENANCE	\$1,000.00	\$1,000.00	14.2
4900 13	TRANSPORTATION	\$1,000.00	\$1,000.00	14.2
4900 14	OFFICE	\$1,000.00	\$1,000.00	21.2
4900 15	CONTRACT LABORERS	\$0.00	\$0.00	21.2
4900 16	MANIFEST	\$0.00	\$0.00	21.2
Total Supplies		\$12,000.00	\$12,000.00	
FIXTURES				
5000 01	ELECTRIC & GAS	\$4,000.00	\$4,000.00	5.3
5000 02	LAND	\$0.00	\$0.00	5.3
5000 03	WATER	\$2,000.00	\$2,000.00	5.3
5000 04	TRASH/RECYCLING	\$4,000.00	\$4,000.00	5.3
5000 05	CABLE TV	\$3,000.00	\$3,000.00	5.3
5000 06	REPAIRS	\$1,000.00	\$1,000.00	5.3
5000 07	REPAIRS & MAINTENANCE	\$1,000.00	\$1,000.00	5.3
5000 08	RENT	\$4,000.00	\$4,000.00	24.3
5000 09	RENT - VEH	\$0.00	\$0.00	25.3
5000 10	RENT - SUPPLY TRUCK	\$0.00	\$0.00	25.3
Total Fixtures		\$17,000.00	\$17,000.00	
GENERAL & ADMINISTRATIVE				
5100 01	TELEPHONE	\$4,000.00	\$4,000.00	21.3
5100 02	DATA & REPRODUCTION	\$4,000.00	\$4,000.00	20.3
5100 03	REPAIRS	\$1,000.00	\$1,000.00	20.3
5100 04	POSTAGE	\$4,000.00	\$4,000.00	21.3
5100 05	POSTAGE	\$0.00	\$0.00	21.3
5100 06	LEGAL & ACCOUNTING	\$0.00	\$0.00	18.3
5100 07	ACCOUNTING	\$1,000.00	\$1,000.00	20.3
5100 08	ACCOUNTING	\$1,000.00	\$1,000.00	20.3
5100 09	TRAVEL & MEALS	\$1,000.00	\$1,000.00	24.3
5100 10	TRAVEL - BUSINESS/RECREATION	\$1,000.00	\$1,000.00	24.3
5100 11	TRAVEL AND TRANSPORT	\$1,000.00	\$1,000.00	20.3
5100 12	LEASING & TRUCK	\$1,000.00	\$1,000.00	20.3
5100 13	SALES TAX	\$0.00	\$0.00	27.3
5100 14	SOFT-PHOTOGRAPHY	\$1,000.00	\$1,000.00	20.3
5100 15	COMMUNITY RELATIONS	\$1,000.00	\$1,000.00	20.3
Total General & Administrative		\$17,000.00	\$17,000.00	
Total Expenses				
		\$1,000,000.00	\$1,000,000.00	
NET INCOME FROM OPERATIONS				
		\$1,437,828.00	\$1,466,828.00	
OPERATIONAL AND SUPPLIES				
5200 01	REPAIRS - VEH	\$0.00	\$0.00	22.3
5200 02	REPAIRS	\$0.00	\$0.00	22.3
5200 03	LEASE OF CREDIT INTEREST	\$0.00	\$0.00	20.3
5200 04	OPERATION	\$0.00	\$0.00	20.3
Total Operational and Supplies		\$0.00	\$0.00	
FINANCIAL EXPENSE INCOME TAXES				
		\$12,000.00	\$12,000.00	
Net Income & Tax		\$1,425,828.00	\$1,454,828.00	

PLEASANT VIEW

Report Period Beginning: 1/1/07 Ending: 12/31/07

Travel and Seminar Analysis

Acct #

9140-00	TRAVEL & SEMINAR		
	Seminars	\$2,602.89	
	Instate travel	\$660.09	
	Other	\$1,006.63	4,270
9141-00	TRAVEL EXPENSES-NON SEMINAR		
	Travel..to other facility	\$372.49	
	Instate travel	\$748.20	
	Local travel to banks	\$681.98	1,803
	Total		6,072
	Per Schedule V line 24		

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	182,526	13,922	7,625	204,073		204,073		204,073		1
2	Food Purchase		123,487		123,487		123,487	(5,134)	118,353		2
3	Housekeeping	55,992	12,157		68,149		68,149		68,149		3
4	Laundry	35,953	20,367		56,320		56,320		56,320		4
5	Heat and Other Utilities			77,900	77,900		77,900		77,900		5
6	Maintenance	55,484	25,318	17,228	98,030		98,030		98,030		6
7	Other (specify):*										7
8	TOTAL General Services	329,955	195,251	102,753	627,959		627,959	(5,134)	622,825		8
	B. Health Care and Programs										
9	Medical Director			19,450	19,450		19,450		19,450		9
10	Nursing and Medical Records	887,276	137,911	87,092	1,112,279	(11,807)	1,100,472	(157)	1,100,315		10
10a	Therapy	25,696		43,663	69,359		69,359		69,359		10a
11	Activities	44,555	8,024	2,150	54,729		54,729		54,729		11
12	Social Services	24,529			24,529		24,529		24,529		12
13	CNA Training	15,416		10,065	25,481		25,481		25,481		13
14	Program Transportation	11,930	3,463		15,393	(3,463)	11,930		11,930		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,009,402	149,398	162,420	1,321,220	(15,270)	1,305,950	(157)	1,305,793		16
	C. General Administration										
17	Administrative			30,000	30,000		30,000	89,739	119,739		17
18	Directors Fees										18
19	Professional Services			15,679	15,679		15,679	54,422	70,101		19
20	Dues, Fees, Subscriptions & Promotions			36,789	36,789		36,789	(3,430)	33,359		20
21	Clerical & General Office Expenses	59,396	13,726	12,731	85,853		85,853	126	85,979		21
22	Employee Benefits & Payroll Taxes			209,852	209,852		209,852	889	210,741		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,292	4,292		4,292	8,330	12,622		24
25	Other Admin. Staff Transportation							1,303	1,303		25
26	Insurance-Prop.Liab.Malpractice			33,337	33,337		33,337	738	34,075		26
27	Other (specify):* SALES TAX			627	627		627	(627)			27
28	TOTAL General Administration	59,396	13,726	343,307	416,429		416,429	151,490	567,919		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,398,753	358,375	608,480	2,365,608	(15,270)	2,350,338	146,199	2,496,537		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: 1/1/07

Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			46,072	46,072		46,072	30,321	76,393			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,927	33,927		33,927	68,659	102,586			32
33	Real Estate Taxes			37,027	37,027		37,027		37,027			33
34	Rent-Facility & Grounds			78,000	78,000		78,000	(78,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* GOODWILL			11,316	11,316		11,316	(11,316)				36
37	TOTAL Ownership			206,342	206,342		206,342	9,664	216,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					3,463	3,463		3,463			38
39	Ancillary Service Centers					5,378	5,378		5,378			39
40	Barber and Beauty Shops					6,429	6,429		6,429			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	15,270	55,785		55,785			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,398,753	358,375	855,337	2,612,465		2,612,465	155,863	2,768,328			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: 1/1/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,134)	2		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	(3,102)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(627)	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	(9,667)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,196)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(12,277)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,503)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (36,503)		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.			\$ 3,463	14	38
39	P.A OXYGEN			5,378	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops			6,429	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)			\$ 15,270		47

BHF USE ONLY						
48		49		50		52

PLEASANT VIEW

ID# 0042416

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	FLOWERS	\$ (804)	20 1
2	GOODWILL	(11,316)	36 2
3	EMPLOYEES AT OTHER FACILITIES	(157)	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	(12,277)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	(5,134)	0	0	0	0	0	0	0	0	0	0	(5,134)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	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	TOTAL General Services	(5,134)	0	0	0	0	0	0	0	0	0	0	(5,134)	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	(157)	0	0	0	0	0	0	0	0	0	0	(157)	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	(157)	0	0	0	0	0	0	0	0	0	0	(157)	16
	C. General Administration													
17	Administrative	0	84,412	5,327	0	0	0	0	0	0	0	0	89,739	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	240	54,182	0	0	0	0	0	0	0	0	54,422	19
20	Fees, Subscriptions & Promotions	(16,167)	0	12,737	0	0	0	0	0	0	0	0	(3,430)	20
21	Clerical & General Office Expenses	0	0	126	0	0	0	0	0	0	0	0	126	21
22	Employee Benefits & Payroll Taxes	0	0	889	0	0	0	0	0	0	0	0	889	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,330	0	0	0	0	0	0	0	0	8,330	24
25	Other Admin. Staff Transportation	0	0	1,303	0	0	0	0	0	0	0	0	1,303	25
26	Insurance-Prop.Liab.Malpractice	0	0	738	0	0	0	0	0	0	0	0	738	26
27	Other (specify):*	(627)	0	0	0	0	0	0	0	0	0	0	(627)	27
28	TOTAL General Administration	(16,794)	84,652	83,632	0	151,490	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,085)	84,652	83,632	0	146,199	29							

STATE OF ILLINOIS

Facility Name & ID Number PLEASANT VIEW

0042416 Report Period Beginning:

1/1/07 Ending:

Summary B

12/31/07

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	30,000	321	0	0	0	0	0	0	0	0	30,321	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,102)	71,500	261	0	0	0	0	0	0	0	0	68,659	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(78,000)	0	0	0	0	0	0	0	0	0	(78,000)	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	(14,418)	23,500	582	0	9,664	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)	(36,503)	108,152	84,214	0	155,863	45							

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

1/1/07

Ending:

12/31/07

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
				OSO PARTNERS	MARION, IA	BLDG. RENTAL
BIG MEADOWS, INC.	100%	BIG MEADOWS	SAVANNA			
AMERICAN HEALTH ENTERPRISES, INC	100%					
ALAN GAPINSKI	100%	WINNING WHEELS	PROPHETSTOWN			
	0%	S.T.R.I.V.E.	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	\$ 78,000	OSO PARTNERS - BUILDING OWNER	100.00%	\$	\$ (78,000)	1
2	V	30 DEPRECIATION				30,000	30,000	2
3	V	32 MORTGAGE INTEREST				71,500	71,500	3
4	V	19 PROFESSIONAL SERVICES				240	240	4
5	V	17 SEE ATTACHED PAGE 6A	30,000	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	114,412	84,412	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		\$ 108,000			\$ 216,152	\$ * 108,152	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 MANAGEMENT FEES	\$ 30,000	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$	(30,000)	15
16	V	17 (SEE PAGE 8)		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	35,327	35,327	16
17	V	19		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	53,863	53,863	17
18	V	19		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	319	319	18
19	V	20		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	12,737	12,737	19
20	V	21		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	126	126	20
21	V	22		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	889	889	21
22	V	24		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	8,330	8,330	22
23	V	25		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,303	1,303	23
24	V	26		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	738	738	24
25	V	30		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	321	321	25
26	V	32		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	245	245	26
27	V	32		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	16	16	27
28	V	6		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	0		28
29	V			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	198	198	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		\$ 30,000			\$ 114,412	\$ * 84,412	39

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

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 MANAGEMENT							2
3										3
4	BIG MEADOWS			100.00				MANAGE. FEES	158,867	4
5	PLEASANT VIEW			100.00				MANAGE. FEES	30,000	5
6	WINNING WHEELS, INC.			NONE				MANAGE. FEES	189,500	6
7	S.T.R.I.V.E.			NONE				MANAGE. FEES	115,750	7
8	OTHER (NON COST REPORTING)			NONE				MANAGE. FEES	145,750	8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 639,867	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: 1/1/07

Ending: 12/31/07

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	\$ 35,327	\$ 48,064	1	\$ 35,327	1
2	17	ADMIN.	GROSS REVENUE	12,018,660	5	274,460	2,358,675	53,863	2
3	19	DATA PROCESSING	GROSS REVENUE	12,018,660	5	1,625	2,358,675	319	3
4	19	ACCOUNTING	GROSS REVENUE	12,018,660	5	64,901	64,901	12,737	4
5	20	DUES, FEES	GROSS REVENUE	12,018,660	5	640	2,358,675	126	5
6	21	SUPPLIES, TELEPHONE	GROSS REVENUE	12,018,660	5	4,531	2,358,675	889	6
7	22	BENEFITS	% OF SALARY	314,319	5	54,473	48,064	8,330	7
8	24	TRAINING, SEMINARS	GROSS REVENUE	12,018,660	5	6,642	2,358,675	1,303	8
9	25	ADMIN. TRANSPORTATION	GROSS REVENUE	12,018,660	5	3,761	2,358,675	738	9
10	26	INSURANCE	GROSS REVENUE	12,018,660	5	1,635	2,358,675	321	10
11	30	DEPRECIATION	GROSS REVENUE	12,018,660	5	1,250	2,358,675	245	11
12	32	INTEREST VEHICLES	GROSS REVENUE	12,018,660	5	81	2,358,675	16	12
13	32	INTEREST WORKING CAPITAL	GROSS REVENUE	12,018,660	5		2,358,675	0	13
14	6	MAINTENANCE SUPPLIES	GROSS REVENUE	12,018,660	5	1,011	2,358,675	198	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 450,337	\$ 112,965		\$ 114,412	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	\$	1								
2	AMCORE BANK		X	CORPORATE VEHICLE	\$1,003.00	9/2006	32,000		9/2009	6.5000		2								
3												3								
4												4								
5												5								
Working Capital																				
6	THE NATIONAL BANK		X	WORKING CAPITAL	\$3,122.73	6/9/2004		27,357	6/9/2009	7.0000	28,708	6								
7	OSO PARTNERS	X		WORKING CAPITAL	\$1,636.21	12/8/96	167,700	56,441	12/8/2010	6.7500	5,219	7								
8	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	25,000		7/2010	5.0000		8								
9	TOTAL Facility Related				\$17,352.94		\$ 1,574,700	\$ 83,798			\$ 33,927	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,574,700	\$ 83,798			\$ 33,927	15								

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

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

** 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT VIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0042416

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>37,842.42</u>	\$ <u>37,842.42</u>
2. _____	<u>MF 10831-96 28603x</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>37,842.42</u>	\$ <u>37,842.42</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

1/1/07 Ending:

12/31/07

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:

1/1/07

Ending:

12/31/07

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74		1996	1974	\$ 1,200,000	\$	39	\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		WATER HEATER		1997	1,582	79	20	79		870	9
10		GARAGE/STORAGE		1997	1,670	84	20	84		919	10
11		BUILT-IN WHIRLPOOL BATHING SYSTEM		1997	22,217	705	10	705		22,217	11
12		CIRCULATING PUMP		1997	1,353		10			1,353	12
13		FLOOR TILE		1997	1,430	95	15	95		1,025	13
14		REMODEL OFFICES		1997	8,092	405	10	405		8,092	14
15		FURNACES		1997	16,130	1,075	15	1,075		11,470	15
16		ROOM SIGNAGE		1997	1,666	83	10	83		1,666	16
17		PAINTING		1997	12,962		7			12,962	17
18		LOCKS & PLATE PLAQUES		1997	820	41	10	41		820	18
19		WINDOW TREATMENTS		1997	772		5			772	19
20		WINDOW TREATMENTS		1997	5,228	261	10	261		5,228	20
21		DOOR ALARM SYSTEMS		1997	12,550	627	10	627		12,550	21
22		LANDSCAPING		1997	13,055	653	10	653		13,055	22
23		SEAL PARKING LOT		1997	2,926		5			2,926	23
24		OFFICE REMODELING (ADDT'L)		1998	6,367		7			6,367	24
25		BEAUTY SHOP REMODELING		1998	6,844	342	20	342		3,336	25
26		AIR CONDITIONING/HEATING UNITS		1998	6,332	422	15	422		3,870	26
27		SPRINKLER SYSTEM		1999	10,944	730	15	730		6,506	27
28		POLYVINYL FENCING		1999	2,133	142	15	142		1,220	28
29		GAZEBO		1999	7,383	492	15	492		4,184	29
30		REMODEL DINING ROOM		1999	20,459	1,023	20	1,023		8,269	30
31		INSTALL LIGHTS & CEILING FANS (NURSE STATION)		2000	989	49	20	49		391	31
32		65 GALLON WATER HEATER		2000	4,696	470	10	470		3,522	32
33		PLANTER INSTALLATION		2000	3,280	328	10	328		2,460	33
34		KITCHEN REMODELING		2001	13,860	924	15	924		6,468	34
35		AWNING		2001	2,504	250	10	250		1,628	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:

1/1/07

Ending:

12/31/07

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	\$	\$ 1,474	37
38	REMODEL LAUNDRY ROOM	2001	4,714	121	39	121		755	38
39	HEAT TAPE CUTTERS	2001	1,603	160	10	160		1,042	39
40	CEILING, TILE, LIGHTS & INSTALLATION	2002	13,327	888	15	888		5,331	40
41	LAUNDRY ROOM FLOOR TILE	2002	1,125	75	15	75		450	41
42	COMMERCIAL DISPOSAL	2002	951	95	10	95		523	42
43	LAUNDRY ROOM A/C	2002	3,086	309	10	309		1,697	43
44	REPLACE ROOF	2002	47,430	2,372	20	2,372		12,450	44
45	SHUTTERS	2002	852	57	15	57		289	45
46	REMODEL HALLWAY	2003	26,281	2,628	10	2,628		11,827	46
47	MAIN STREET PROJECT	2004	25,169	3,596	7	3,596		12,585	47
48	PHYSICAL THERAPY WALKING AREA	2004	18,427	1,843	10	1,843		6,449	48
49	DECK	2004	8,535	853	10	853		2,987	49
50	GENERATOR	2004	59,537	2,381	25	2,381		88,732	50
51	SECURITY CAMERA	2004	1,519	217	7	217		759	51
52	ROOM WINDOWS	2005	1,448	72	20	72		187	52
53	DRY PIPE VALVE & ASSOCIATED PIPING	2007	2,974	25	20	25		25	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)		\$ 1,607,490	\$ 25,200		\$ 25,200	\$	\$ 291,707	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: 1/1/07 Ending: 12/31/07

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	\$ 161,910	\$ 20,391	\$ 20,391	\$	VARIOUS	\$ 121,425	71
72	Current Year Purchases	5,094	481	481		VARIOUS	481	72
73	Fully Depreciated Assets	89,666				VARIOUS	89,666	73
74								74
75	TOTALS	\$ 256,670	\$ 20,872	\$ 20,872	\$		\$ 211,572	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,914,160	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,072	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,072	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 503,279	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>78,000</u>	<u>5</u>	<u>13</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>74</u>		\$ <u>78,000</u>			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>12/31/2008</u>	\$ <u>78,000</u>
13.	<u>12/31/2009</u>	\$ <u>78,000</u>
14.	<u>12/31/2010</u>	\$ <u>78,000</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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

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

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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>
--	--	---

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)	975	4,814		5,789
4	Clinical Wages (b)		9,627		9,627
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	2,013	8,052		10,065
8	CNA Competency Tests				
9	TOTALS	\$ 2,988	\$ 22,493	\$	\$ 25,481
10	SUM OF line 9, col. 1 and 2 (e)	\$ 25,481			

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	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	78.5 hrs	\$ 3,045		\$	\$	79	\$ 3,045	1
2	Licensed Speech and Language Development Therapist	10a, 3	65.75 hrs	2,630				66	2,630	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	1214 hrs	37,988				1,214	37,988	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			\$ 43,663		\$	\$	1,358	\$ 43,663	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: 1/1/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(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	\$ (346,869)	\$ 121,360	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>346559-23033</u>)	323,526	685,793	3
4	Supply Inventory (priced at <u>COST</u>)	39,505	76,184	4
5	Short-Term Investments			5
6	Prepaid Insurance	4,615	10,577	6
7	Other Prepaid Expenses	1,493	3,483	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>OTHER RECEIVABLE</u>		40,393	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,269	\$ 937,789	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	407,490	433,958	15
16	Equipment, at Historical Cost	256,670	988,705	16
17	Accumulated Depreciation (book methods)	(423,281)	(1,088,809)	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>	44,526	44,526	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 298,355	\$ 408,480	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 320,624	\$ 1,346,269	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 159,950	\$ 443,564	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,757	214,296	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,015	15,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,842	86,058	32
33	Accrued Interest Payable	728	28,456	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO BIG MEADOWS</u>	822,359	(0)	36
37	<u>RESIDENT S.S. PAYABLE</u>	1,768	1,943	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,129,420	\$ 790,097	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	83,798	558,228	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>	309,048	309,048	43
44	<u>DUE TO AHE, INC.</u>	75,507	401,215	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 468,352	\$ 1,465,879	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,597,772	\$ 2,255,976	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,277,148)	\$ (909,707)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 320,624	\$ 1,346,269	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,063,872)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,063,872)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(213,276)	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)	\$ (213,276)	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)	\$ (1,277,148)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning: 1/1/07

Ending: 12/31/07

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	\$ 2,338,093	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,332,093	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,911	6
7	Oxygen	2,403	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 37,315	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	5,548	11
12	Gift and Coffee Shop	77	12
13	Barber and Beauty Care	7,989	13
14	Non-Patient Meals	5,134	14
15	Telephone, Television and Radio	4,508	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)	\$ 23,255	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,102	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	3,267	28
28a	EMPLOYEES AT OTHER LOCATIONS	157	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,424	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,399,189	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	627,959	31
32	Health Care	1,321,220	32
33	General Administration	416,429	33
B. Capital Expense			
34	Ownership	206,342	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)*	\$ 2,612,465	40
41	Income before Income Taxes (line 30 minus line 40)**	(213,276)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (213,276)	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:

1/1/07

Ending:

12/31/07

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	1,435	1,509	\$ 38,305	\$ 25.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,910	8,427	184,421	21.88	3
4	Licensed Practical Nurses	11,922	12,725	238,845	18.77	4
5	CNAs & Orderlies	39,400	43,976	408,973	9.30	5
6	CNA Trainees	1,894	1,894	15,416	8.14	6
7	Licensed Therapist	368	393	10,347	26.33	7
8	Rehab/Therapy Aides	1,028	1,190	15,349	12.90	8
9	Activity Director	1,833	1,960	25,119	12.82	9
10	Activity Assistants	2,174	2,273	19,436	8.55	10
11	Social Service Workers	1,518	1,666	24,529	14.72	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,198	28,960	13.18	13
14	Head Cook	4,626	5,065	48,839	9.64	14
15	Cook Helpers/Assistants	12,085	13,075	104,727	8.01	15
16	Dishwashers					16
17	Maintenance Workers	3,780	4,156	55,484	13.35	17
18	Housekeepers	6,115	6,443	55,992	8.69	18
19	Laundry	4,504	4,580	35,953	7.85	19
20	Administrator	352	352	8,512	24.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,872	2,088	27,722	13.28	23
24	Clerical	2,249	2,405	23,162	9.63	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	1,261	1,424	16,732	11.75	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	933	1,035	11,930	11.53	33
34	TOTAL (lines 1 - 33)	109,221	118,834	\$ 1,398,753 *	\$ 11.77	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	152	\$ 7,625	1,3	35
36	Medical Director		19,450	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	17	660	10,3	39
40	Physical Therapy Consultant	1,214	37,988	10a,3	40
41	Occupational Therapy Consultant	79	3,045	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	66	2,630	10a,3	43
44	Activity Consultant	29	1,150	11,3	44
45	Social Service Consultant	1	1,000	11,3	45
46	Other(specify) LAB		3,150	10,3	46
47	X-RAY		612	10,3	47
48	WINNING WHEELS THERAPISTS	39	1,502	10,3	48
49	TOTAL (lines 35 - 48)	1,596	\$ 78,812		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	665	\$ 49,067	10,3	50
51	Licensed Practical Nurses	258	9,117	10,3	51
52	Certified Nurse Assistants/Aides	1,048	22,985	10,3	52
53	TOTAL (lines 50 - 52)	1,972	\$ 81,168		53

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning: 1/1/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DEANE PATTEN	ADMINISTRATOR	NONE	\$	Workers' Compensation Insurance	\$ 53,770	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	15,876	Advertising: Employee Recruitment	10,796	
				FICA Taxes	105,324	Health Care Worker Background Check		
				Employee Health Insurance	10,430	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	1,710	
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	5,477	
				DISABILITY INSURANCE	10,732	ADVERTISING	14,486	
				LIFE INSURANCE	2,746	PRINTING	1,445	
				401K RETIREMENT	3,793	COMMUNITY RELATIONS	1,881	
				PHYSICALS	670			
				EMPLOYEE RECOGNITION	5,911	Less: Public Relations Expense	(1,681)	
				PROFESSIONAL LICENSE FEE	600	Non-allowable advertising	(9,290)	
				HOME OFFICE ALLOCATION		Yellow page advertising	(5,196)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$				\$ 209,852			\$ 20,622	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description				Description				
Amount				Line #				
AHE, INC. MANAGEMENT CONTRACT								
Amount				Amount				
(INCLUDES ADMINISTRATOR SALARY & BENEFITS)								
\$ 30,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL				
\$ 30,000				\$				
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee				Description				
Type				Amount				
CREATIVE SOLUTIONS				Out-of-State Travel				
MEDICAL RECORDS				\$				
ACHIEVE SOFTWARE								
SOFTWARE MAINTENANCE								
JOHN PYSE				In-State Travel				
COMPUTER CONSULTANT				MILEAGE REIMBURSEMENT				
AMOUNT				1,121				
IVANS								
MEDICARE A DIALUP FEES				Seminar Expense				
AMOUNT				3,171				
EHEALTH DATA SOLUTIONS				(DETAILED ATTACHED)				
MDS/QUALITY SOFTWARE								
MIDWEST AUTOMATED TIME								
TIME CLOCK MAINTENANC								
AMOUNT								
WARD, MURRAY, PACE				Entertainment Expense				
LEGAL				(
AMOUNT)				
84				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 15,679				\$ 4,292				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PLEASANT VIEW

Report Period Beginning: 1/1/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	PAINTING		\$ 899	5	\$ 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	\$ 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 - \$4,236
- (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. \$ 15,360 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 \$5,000, 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.

PIN NUMBER	TOWNSHIP	CLASS CODE	2006 PAYABLE	2007	TAX CODE	BACK TAX	
09-17-130-001	Mt. Pleasant	3036			00805		
Taxing Body							
	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Difference Amount	Pension Amount	Library Amount
WHITESIDE COUNTY	1.0416	\$4,374.72	1.0582	\$4,444.44	\$69.72	\$1,259.58	\$0.00
MORRISON HOSPITAL	0.6240	\$2,820.80	0.5842	\$2,453.64	(\$167.16)	\$905.52	\$0.00
SAUK VALLEY NO 508	0.4595	\$1,929.90	0.4596	\$1,930.32	\$0.42	\$47.46	\$0.00
UNION GROVE-MT. PLEASANT #5	0.0462	\$194.04	0.0464	\$194.88	\$0.84	\$0.00	\$0.00
MT PLEASANT TOWNSHIP	0.1447	\$607.74	0.1447	\$607.74	\$0.00	\$16.36	\$0.00
MT PLEASANT TOWNSHIP ROAD	0.3017	\$1,267.14	0.3015	\$1,266.90	(\$0.84)	\$34.02	\$0.00
MORRISON UNIT NO 6	5.5194	\$23,181.48	5.3672	\$22,542.24	(\$639.24)	\$732.48	\$0.00
MORRISON CITY	1.0571	\$4,481.82	1.0483	\$4,402.86	(\$78.96)	\$1,893.32	\$624.96
Totals	9.2042	\$38,657.64	9.0101	\$37,842.42	(\$815.22)	\$4,988.76	\$624.96

TIP BASE	0
1977 EQUALIZED	0
SAF BASE	0
MARKET VALUE	1,260,000
TOTAL ACRES	5.49
LAND VALUE	5,200
BUILDING VALUE	414,800
DISABLED VET	0
ASSESSED VALUE	420,000
STATE MULTIPLIER	1.0000
EQUALIZED VALUE	420,000
OWNER OCCUPIED	0
SENIOR EXMPT	0
SAF/VET/FRAT	0
FARM LAND	0
FARM BUILDING	0
NET TAXABLE VAL.	420,000
TAX RATE	9.0101
CURRENT TAX	\$37,842.42
DRAINAGE	\$0.00
ENTERPRISE ZONE	\$0.00
CURRENT TAX DUE	\$37,842.42
TOTAL TAX PAID	\$0.00
TOTAL TAX DUE	\$37,842.42

PLEASE READ REVERSE SIDE FOR IMPORTANT INFORMATION
MAKE CHECKS PAYABLE TO: WHITESIDE COUNTY COLLECTOR
 200 EAST KNOX
 MORRISON, IL 61270

PENALTY INTEREST OF 1.12% PER MONTH ADDED AFTER EACH INSTALLMENT DUE DATE FOR EACH MONTH OR PART OF A MONTH.	
1ST DUE DATE	06/15/2007
2ND DUE DATE	09/05/2007
1ST INSTALLMENT	\$18,921.21
2ND INSTALLMENT	\$18,921.21
COSTS	INTEREST
TOTAL PAID	TOTAL PAID
STAMP PAID HERE 1ST INSTALLMENT	STAMP PAID HERE 2ND INSTALLMENT

RECEIPT PORTION - KEEP FOR YOUR RECORDS

Site Address: _____

Owner's Name: **OSO PARTNERS LLC**

Legal Description: **PT NW SEC 17 TWP 21 RNG 5 MF 10831-96 28603x**



PIN NUMBER	09-17-130-001	FORFEITED TAXES OR YEARS	
CURRENT TAX DUE	\$18,921.21	TAX PAYMENT - 1ST INST	
DUE DATE	06/15/2007	COSTS	INTEREST
TOTAL ANNUAL TAX	\$37,842.42	TOTAL PAID	

09-17-130-001
 OSO PARTNERS LLC
 %AMERICAN HEALTH ENT
 501 W 6TH AVE
 LYNDON, IL 61261-0000



PIN NUMBER	09-17-130-001	FORFEITED TAXES OR YEARS	
CURRENT TAX DUE	\$18,921.21	TAX PAYMENT - 2ND INST	
DUE DATE	09/05/2007	COSTS	INTEREST
TOTAL ANNUAL TAX	\$37,842.42	TOTAL PAID	

09-17-130-001
 OSO PARTNERS LLC
 %AMERICAN HEALTH ENT
 501 W 6TH AVE
 LYNDON, IL 61261-0000