		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0020628

Facility Name: FOUNTAINVIEW

Address: 1001 A JEFFERSON STREET (Number) ELDORADO (City) 62930 (Zip Code)

County: SALINE

Telephone Number: 618-273-3353 **Fax #** 618-273-4800

HFS ID Number:

Date of Initial License for Current Owners: 08-17-1976

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BILLY L. JONES **Telephone Number:** 618-273-3353
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07-01-2009 to 06-30-2010 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) BILLY L. JONES
(Title) MANAGER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) ROGER W. BAGLEY, VICE-PRESIDENT
(Firm Name & Address) JAMESTOWN MANAGEMENT CORPORATION, 1001 E. MAIN, CARBONDALE, IL
(Telephone) 618-549-8331 Fax # 618-549-0133

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 FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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 07-01-2009

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	38	Skilled (SNF)	38	13,870	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	804		2,829	3,633	8
9	SNF/PED					9
10	ICF	19,267	14,705		33,972	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,071	14,705	2,829	37,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.82%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08-17-1976

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 2,829

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12-31-2010 Fiscal Year: 06-30-2010

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

Facility Name & ID Numbe: FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	139,932	12,712	10,701	163,345		163,345		163,345			1
2	Food Purchase		178,979		178,979		178,979		178,979			2
3	Housekeeping	118,857	14,050		132,907		132,907		132,907			3
4	Laundry	57,248	12,712		69,960		69,960		69,960			4
5	Heat and Other Utilities			87,414	87,414		87,414		87,414			5
6	Maintenance	35,449	27,306	56,702	119,457		119,457		119,457			6
7	Other (specify):*											7
8	TOTAL General Services	351,486	245,759	154,817	752,062		752,062		752,062			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	1,315,686	41,654	2,704	1,360,044		1,360,044		1,360,044			10
10a	Therapy	12,155			12,155		12,155		12,155			10a
11	Activities	60,941	2,245		63,186		63,186		63,186			11
12	Social Services	44,949		4,972	49,921		49,921		49,921			12
13	CNA Training											13
14	Program Transportation			3,348	3,348		3,348		3,348			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,433,731	43,899	11,524	1,489,154		1,489,154		1,489,154			16
	C. General Administratior											
17	Administrative	66,978			66,978		66,978		66,978			17
18	Directors Fees			21,000	21,000		21,000		21,000			18
19	Professional Services			45,690	45,690		45,690		45,690			19
20	Dues, Fees, Subscriptions & Promotions			11,678	11,678		11,678	(4,672)	7,006			20
21	Clerical & General Office Expenses	88,759	10,254	17,990	117,003		117,003	(11,732)	105,271			21
22	Employee Benefits & Payroll Taxes			357,729	357,729		357,729	(2,864)	354,865			22
23	Inservice Training & Educatior											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,251	62,251		62,251		62,251			26
27	Other (specify):*											27
28	TOTAL General Administration	155,737	10,254	516,338	682,329		682,329	(19,268)	663,061			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,940,954	299,912	682,679	2,923,545		2,923,545	(19,268)	2,904,277			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100

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

Facility Name & ID Numbe FOUNTAINVIEW #0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,982	59,982		59,982	9,987	69,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			37,232	37,232		37,232		37,232			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			97,214	97,214		97,214	9,987	107,201			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,908	222,294	327,202		327,202		327,202			39
40	Barber and Beauty Shops	12,343	1,100		13,443		13,443		13,443			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	12,343	106,008	283,067	401,418		401,418		401,418			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,953,297	405,920	1,062,960	3,422,177		3,422,177	(9,281)	3,412,896			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 Numbe FOUNTAINVIEW # 0020628 Report Period Beginning 07-01-2009 Ending: 06-30-2010

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciatior	9,987	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(2,864)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax	(11,732)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,672)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (9,281)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatior Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (9,281)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

FOUNTAINVIEW

ID# 0020628

Report Period Beginning: 07-01-2009

Ending: 06-30-2010

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-2009 **Ending:** 06-30-2010

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,672)	0	0	0	0	0	0	0	0	0	0	(4,672)	20
21	Clerical & General Office Expenses	(11,732)	0	0	0	0	0	0	0	0	0	0	(11,732)	21
22	Employee Benefits & Payroll Taxes	(2,864)	0	0	0	0	0	0	0	0	0	0	(2,864)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(19,268)	0	0	0	0	0	0	0	0	0	0	(19,268)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,268)	0	0	0	0	0	0	0	0	0	0	(19,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOUNTAINVIEW **#** 0020628 **Report Period Beginning:** 07-01-2009 **Ending:** 06-30-2010

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	9,987	0	0	0	0	0	0	0	0	0	0	9,987	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,987	0	0	0	0	0	0	0	0	0	0	9,987	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)**	(9,281)	0	0	0	0	0	0	0	0	0	0	(9,281)	45

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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
ROBERT G. MORGAN	6.76	POPE COUNTY CARE CENTER	GOLCONDA			

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	ALBERT G. BLEDIG	PRESIDENT	EXEC BOARD	23.66		2		DIR FEES	$ 3,000	18-3	1
2	DON R. DEARMON	SECRETARY	EXEC BOARD	23.66		2		DIR FEES	3,000	18-3	2
3	BILLY L. JONES	TREASURER	EXEC BOARD	15.12		2		DIR FEES	3,000	18-3	3
4	BILLY L. JONES	BUS MANAGER	MANAGE FAC	15.12		18		BUS MGR	34,600	19-3	4
5	EVERETT KNIGHT	DIRECTOR	EXEC BOARD	6.00		2		DIR FEES	3,000	18-3	5
6	ROBERT G. MORGAN	VICE PRES	EXEC BOARD	6.76		2		DIR FEES	3,000	18-3	6
7	JAMES B CHILDRESS	DIRECTOR	EXEC BOARD	13.52		2		DIR FEES	3,000	18-3	7
8	MARK W. KNIGHT	DIRECTOR	EXEC BOARD	4.52		2		DIR FEES	3,000	18-3	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,600		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 FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 6-30-2010

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 [X]

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

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

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ NONE	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. (See instructions.)**

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

Facility Name & ID Numbe FOUNTAINVIEW # 0020628 Report Period Beginning 07-01-2009 Ending: 06-30-2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 56,675	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 37,472	2
3. Under or (over) accrual (line 2 minus line 1).		$ (19,203)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,435	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru (		$ 37,232	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	34,895	8
	2006	34,897	9
	2007	35,326	10
	2008	36,834	11
	2009	37,472	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual (taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of a application for real estate tax exemption unless the building is rented from a for-profit enti**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOUNTAINVIEW COUNTY SALINE

FACILITY IDPH LICENSE NUMBER 0020628

CONTACT PERSON REGARDING THIS REPORT BILLY L JONES

TELEPHONE 618-273-3353 FAX #: 618-273-4800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-1-159-04	FACILITY 4.89 ACRES	$ 37,378.00	$ 37,378.00
2.	04-2-095-06	FACILITY ADDL LOT	$ 99.68	$ 99.68
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,477.68	$ 37,477.68

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,659 B. General Construction Type: Exterior MASONARY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	217,800	1976	$ 21,500	1
2	FACILITY	5,000	2006	645	2
3	TOTALS	222,800		$ 22,145	3

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	42		1976	1976	$ 324,614	$	27	$	$	$ 324,614	4
5	57		1976	1976	519,630		30			519,630	5
6	12		1983	1983	273,457		30	9,115	9,115	243,847	6
7			1993	1993	159,083	3,182	50	3,182		54,359	7
8			1998	1998	17,723	354	50	354		4,130	8
	Improvement Type**										
9	ROOF			1982	20,564		10			20,564	9
10	ROOF			1988	14,123		10			14,123	10
11	ROOF			1990	10,586		10			10,586	11
12	LIFT			1991	3,572		10	179	179	3,484	12
13	OUTSIDE LIGHTS			1991	1,345		10			1,345	13
14	ROOF			1991	13,600		20	680	680	12,750	14
15	KITCHEN LIGHTS			1992	1,208		20	60	60	1,095	15
16	HAC UNITS			1992	26,114		15			26,114	16
17	ROOF			1992	9,000	450	20	450		7,950	17
18	HAC UNITS			1993	7,578		15			7,578	18
19	FENCE			1993	8,581	429	20	429		7,257	19
20	HAC UNITS			1993	2,023		15			2,023	20
21	HAC UNITS			1994	2,777		15			2,777	21
22	HAC UNITS			1994	2,124		15			2,124	22
23	HAC UNITS			1995	5,723	382	15	382		2,857	23
24	HAC UNITS			1996	4,050	270	15	270		3,915	24
25	REMODELING			1997	20,514	1,026	20	1,026		9,633	25
26	ROOF			1997	35,935		7			35,935	26
27	HAC UNITS			1997	3,375	225	15	225		2,738	27
28	PARKING LOT & DRAINAGE			1998	44,413	888	50	888		10,360	28
29	DUMPSTER			1998	1,931	97	20	97		1,130	29
30	ROOF			1998	3,800		7			3,800	30
31	FIRE ALARM SYSTEM			1999	48,588	2,429	20	2,429		25,707	31
32	KITCHEN REMODELING			2000	7,307	365	20	365		3,680	32
33	METAL CANOPY			2000	3,508	175	20	175		1,808	33
34	ROOM NUMBERS & NAME PLATES			2000	1,472	73	20	73		754	34
35	LANDSCAPING			2000	1,411	71	20	71		722	35
36	FIRE SHUTTERS & BASEBOARDS			2001	6,991	699	10	699		6,408	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 FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HEATERS	2001	$ 2,054	$ 137	15	$ 137	$	$ 1,244	37
38	EMERGENCY POWER SUPPLY	2001	54,674	2,781	20	2,734	(47)	24,425	38
39	WINDOWS	2001	11,446	572	20	572		4,958	39
40	CABINETS	2002	3,174	159	20	159		1,312	40
41	HAC UNITS	2002	4,030	269	15	269		2,286	41
42	WATER HEATER	2003	3,470	174	20	174		1,305	42
43	ROOF	2004	34,230	1,712	20	1,712		11,698	43
44	WINDOWS	2004	4,308	215	20	215		1,362	44
45	AC UNIT	2004	638	64	10	64		442	45
46	AC UNIT	2004	3,000	200	15	200		1,233	46
47	BATHROOM RAILS	2004	344	17	20	17		103	47
48	COURT YARD	2005	33,997	1,700	20	1,700		9,917	48
49	BATHROOM REMODELING	2005	19,729	986	20	986		5,670	49
50	ROOF	2005	12,600	1,260	10	1,260		7,560	50
51	AC UNIT	2005	1,079	72	15	72		384	51
52	ELECTRICAL IMPROVEMENTS	2006	11,050	737	15	737		3,562	52
53	DOOR	2006	1,750	117	15	117		526	53
54	HAC UNITS	2006	5,075	338	15	338		1,549	54
55	HAC UNITS	2008	6,426	428	15	428		749	55
56	FLOOR TILING	1985	4,671		15			4,671	56
57	DOORS & SPRINKLERS	1988	4,116		20			4,116	57
58	SINK	1990	852		7			852	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)		$ 1,829,433	$ 23,053		$ 33,040	$ 9,987	$ 1,465,721	70

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	$ 384,566	$ 28,144	$ 28,144	$		$ 208,815	71
72	Current Year Purchases	33,702	2,482	2,482		7YR	2,482	72
73	Fully Depreciated Assets	182,943					182,943	73
74								74
75	TOTALS	$ 601,211	$ 30,626	$ 30,626	$		$ 394,240	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	TRANSPORT RESIDENTS	95 CHEVY VAN	1998	$ 12,775	$	$	$	10	$ 12,775	76
77	TRANSPORT RESIDENTS	98 FORD VAN	1999	26,198	1,319	1,319		10	26,198	77
78	TRANSPORT RESIDENTS	2000 FORD VAN	2009	8,000	1,600	1,600		5	2,667	78
79	TRANSPORT RESIDENTS	2008 FORD VAN	2010	34,805	3,384	3,384		10	3,384	79
80	TOTALS			$ 81,778	$ 6,303	$ 6,303	$		$ 45,024	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)	$ 2,534,567	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 59,982	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,969	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,987	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,904,985	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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		$	$ NONE	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.

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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.

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   WE HIRE ONLY CNAS WITH CERTIFICATES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$	5,257	$ 92,744	$	5,257	$ 92,744	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		166	10,102		166	10,102	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		1,718	100,141	325	1,718	100,466	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB & XRAY	39-3				19,307			19,307	12
13	Other (specify): DRUGS & MED SUPP	39-2					104,583		104,583	13
14	TOTAL			$	7,141	$ 222,294	$ 104,908	7,141	$ 327,202	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed o
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be liste
on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06-30-2010 (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	$ 365,817	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance)	565,944		3
4	Supply Inventory (priced a COST)	14,476		4
5	Short-Term Investments	762,846		5
6	Prepaid Insurance	24,879		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties			8
9	Other(specify): EMPLOYEE LOANS	14,865		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,748,827	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,145		13
14	Buildings, at Historical Cost	1,829,433		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	682,989		16
17	Accumulated Depreciation (book methods	(1,948,421)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 586,146	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,334,973	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 109,848	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,483		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,222		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,435		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	24,307		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 306,295	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 306,295	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,028,678	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,334,973	$	48

***(See instructions.)**

Facility Name & ID Numbe FOUNTAINVIEW # 0020628 Report Period Beginning 07-01-2009 Ending: 06-30-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,825,906	1
2	Restatements (describe)		2
3	**PRIOR PERIOD MEDICARE ADJUSTMENT**	33,219	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,859,125	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43	769,553	7
8	Aquisitions of Pooled Companie		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purpose		12
13	Dividends Paid or Other Distributions to Owner	(600,000)	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 169,553	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,028,678	24 *

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

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,198,413	1
2	Discounts and Allowances for all Levels	(18,797)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,179,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,353	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,781	13
14	Non-Patient Meals	120	14
15	Telephone, Television and Radio		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**	$ 3,254	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	7,360	28
28a	EQUIPMENT SALE	1,500	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,860	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,191,730	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	752,062	31
32	Health Care	1,489,154	32
33	General Administration	682,329	33
	B. Capital Expense		
34	Ownership	97,214	34
	C. Ancillary Expense		
35	Special Cost Centers	340,645	35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,422,177	40
41	**Income before Income Taxes (line 30 minus line 40)****	769,553	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 769,553	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 70,044	$ 33.68	1
2	Assistant Director of Nursing	2,000	2,080	44,108	21.21	2
3	Registered Nurses	8,587	9,039	180,843	20.01	3
4	Licensed Practical Nurses	24,905	26,427	406,181	15.37	4
5	CNAs & Orderlies	64,995	67,431	602,816	8.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	999	1,159	12,155	10.49	8
9	Activity Director	1,836	1,956	19,833	10.14	9
10	Activity Assistants	3,440	3,752	41,108	10.96	10
11	Social Service Workers	3,981	4,077	44,949	11.03	11
12	Dietician					12
13	Food Service Supervisor	1,931	1,979	19,843	10.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,798	14,493	120,089	8.29	15
16	Dishwashers					16
17	Maintenance Workers	2,105	2,259	35,449	15.69	17
18	Housekeepers	12,837	14,521	118,857	8.19	18
19	Laundry	6,446	6,778	57,248	8.45	19
20	Administrator	2,000	2,080	66,978	32.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,102	6,338	88,759	14.00	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	1,097	1,205	11,694	9.70	31
32	Other Health Care(specify)					32
33	Other(specify) beauty shop	1,144	1,240	12,343	9.95	33
34	TOTAL (lines 1 - 33)	160,203	168,894	$ 1,953,297 *	$ 11.57	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 10,701	1-3	35
36	Medical Director	12	500	9-3	36
37	Medical Records Consultant	32	1,553	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,151	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	72	4,972	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 18,877		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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)		$ none		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEVE JOHNSON	ADMINISTRATOR	NONE	$ 66,978
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,978

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BILLY L. JONES	MANAGER	$ 32,670
JAMESTOWN MANAGEMENT	ACCOUNTING	5,880
JAMES HENSON CPA	ACCOUNTING	5,771
LISA BERRY	FINANCIALS	480
DAVID HAUPTMAN	LEGAL	889
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 45,690

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,626
Unemployment Compensation Insurance	30,386
FICA Taxes	144,940
Employee Health Insurance	21,192
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE	2,153
RETIREMENT	14,398
UNIFORM ALLOWANCE	3,956
EMPLOYEE CHRISTMAS PARTY	1,744
DRUG & BACKGROUND CHECKS	2,045
SAFETY TRAINING	1,100
WORKSHOPS	6,325
TOTAL (agree to Schedule V, line 22, col.8)	$ 354,865

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,101
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
YELLOW PAGES	4,672
LICENSES-LAB,KIT,ADMIN	450
CORP ANNUAL FEE	250
FLOWERS	1,227
FAMILY EXPENSES	2,978
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(4,672)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,006

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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 repor **NO**
If YES, give association name and amount

(3) Did the nursing home make political contributions or payments to a politic 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 t 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 perioc **7YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expen and the location of this expense on Sch. V. $ **22,762** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur 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 f 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 ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme during this cost report period. $ **60,773**
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 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 t the Department, in addition to the daily rate, been properly classifie 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 f 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, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benef on Schedule V. $ **NONE** Has any meal income been offset agains related costs? **NONE** Indicate the amount $ **NONE**

(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 f residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $ **NONE**
c. What percent of all travel expense relates to transportation of nurses and patients **N/A**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjuste 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 firn **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of servic performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee