FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 002-0628

Facility Name: FOUNTAINVIEW, INC

Address: U.S. ROUTE 45 (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 07-01-2010 to 06-30-2011 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, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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	365		2,763	3,128	8
9	SNF/PED					9
10	ICF	19,053	13,639		32,692	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,418	13,639	2,763	35,820	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.41%

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 2,763

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: 12-31-2011 Fiscal Year: 06-30-2011

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

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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	145,668	12,620	10,777	169,065		169,065		169,065			1
2	Food Purchase		182,729		182,729		182,729		182,729			2
3	Housekeeping	118,045	14,448		132,493		132,493		132,493			3
4	Laundry	56,673	12,799		69,472		69,472		69,472			4
5	Heat and Other Utilities			90,433	90,433		90,433		90,433			5
6	Maintenance	36,398	7,319	77,064	120,781		120,781		120,781			6
7	Other (specify):*											7
8	TOTAL General Services	356,784	229,915	178,274	764,973		764,973		764,973			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	1,344,153	55,186	14,547	1,413,886		1,413,886		1,413,886			10
10a	Therapy											10a
11	Activities	67,686	1,136		68,822		68,822		68,822			11
12	Social Services	45,062		5,334	50,396		50,396		50,396			12
13	CNA Training											13
14	Program Transportation			2,254	2,254		2,254		2,254			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,456,901	56,322	22,635	1,535,858		1,535,858		1,535,858			16
	C. General Administration											
17	Administrative	69,026			69,026		69,026		69,026			17
18	Directors Fees			20,300	20,300		20,300		20,300			18
19	Professional Services			53,781	53,781		53,781		53,781			19
20	Dues, Fees, Subscriptions & Promotions			14,769	14,769		14,769	(7,466)	7,303			20
21	Clerical & General Office Expenses	86,950	9,154	20,653	116,757		116,757	(14,995)	101,762			21
22	Employee Benefits & Payroll Taxes			320,290	320,290		320,290		320,290			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,337	10,337		10,337		10,337			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,000	64,000		64,000		64,000			26
27	Other (specify):*											27
28	TOTAL General Administration	155,976	9,154	504,130	669,260		669,260	(22,461)	646,799			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,969,661	295,391	705,039	2,970,091		2,970,091	(22,461)	2,947,630			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 FOUNTAINVIEW, INC #002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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			64,226	64,226		64,226		64,226			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,506	1,506		1,506		1,506			32
33	Real Estate Taxes			41,015	41,015		41,015		41,015			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			106,747	106,747		106,747		106,747			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,099	202,167	291,266		291,266		291,266			39
40	Barber and Beauty Shops	7,532			7,532		7,532		7,532			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**	7,532	89,099	262,940	359,571		359,571		359,571			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,977,193	384,490	1,074,726	3,436,409		3,436,409	(22,461)	3,413,948			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 FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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				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	(520)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,074)	21		24
25	Fund Raising, Advertising and Promotional	(2,260)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,401)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,206)	20		28
29	Other-Attach Schedule RENT INCOME	(3,000)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,461)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (22,461)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FOUNTAINVIEW, INC

ID# 002-0628

Report Period Beginning: 07-01-2010

Ending: 06-30-2011

	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, INC **#** 002-0628 **Report Period Beginning:** 07-01-2010 **Ending:** 06-30-2011

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	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	(7,466)	0	0	0	0	0	0	0	0	0	0	(7,466)	20
21	Clerical & General Office Expenses	(11,995)	0	0	0	0	0	0	0	0	0	0	(11,995)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	(19,461)	0	0	0	0	0	0	0	0	0	0	(19,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,461)	0	0	0	0	0	0	0	0	0	0	(19,461)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number FOUNTAINVIEW, INC **#** 002-0628 **Report Period Beginning:** 07-01-2010 **Ending:** 06-30-2011

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	(19,461)	0	0	0	0	0	0	0	0	0	0	(19,461)	45

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALBERT G BLEDIG	PRESIDENT	EXEC BOARD	30.81		2		DIR FEES	$ 3,300		1
2	DON R. DEARMAON	SECRETARY	EXEC BOARD	26.49		2		DIR FEES	2,550		2
3	BILLY L JONES	TREASURER	EXEC BOARD	19.07		2		DIR FEES	3,300		3
4	BILLY L JONES	BUS MANAGER	MANAGE FAC	19.07		18		BUS MGR	34,600		4
5	EVERETT KNIGHT	DIRECTOR	EXEC BOARD	8.86		2		DIR FEES	3,050		5
6	ROBERT G. MORGAN	VICE PRES	EXEC BOARD	7.57		2		DIR FEES	3,300		6
7	JAMES B CHILDRESS	DIRECTOR	EXEC BOARD	0.00		2		DIR FEES	1,500		7
8	MARK W. KNIGHT	DIRECTOR	EXEC BOARD	7.20		2		DIR FEES	3,300		8
9											9
10											10
11											11
12											12
13								TOTAL	$ 54,900		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, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 6-30-2011

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, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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	JAMES B CHILDERS		X	WORKING CAPITAL	NONE	01/01/11	200,000	154,396	01/01/16	0.0150	1,506	6
7												7
8												8
9	TOTAL Facility Related						$ 200,000	$ 154,396			$ 1,506	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 200,000	$ 154,396			$ 1,506	15

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

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

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

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 **Report Period Beginning:** 07-01-2010 **Ending:** 06-30-2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 56,435	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.)		$ 37,477	2
3. Under or (over) accrual (line 2 minus line 1).		$ (18,958)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 59,973	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 41,015	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	34,897	8
	2007	35,326	9
	2008	36,834	10
	2009	37,472	11
	2010	37,477	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOUNTAINVIEW, INC COUNTY SALINE

FACILITY IDPH LICENSE NUMBER 002-0628

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 2010 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 2010.

	(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	$ 38,593.00	$ 38,593.00
2.	04-2-095-06	FACILITY ADDL LOT	$ 103.00	$ 103.00
3.	04-1-137-14	RENTAL HOUSE	$ 1,299.00	$ 1,299.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,995.00	$ 39,995.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$		$	$	$ 324,614	4
5	57		1976	1976	519,630					519,630	5
6	12		1983	1983	273,457					273,457	6
7			1993	1993	159,083	3,182		3,182		57,539	7
8			1998	1998	17,723	354		354		4,485	8
	Improvement Type**										
9	ROOF			1982	20,565					20,565	9
10	ROOF			1988	14,123					14,123	10
11	ROOF			1990	10,586					10,586	11
12	LIFT			1991	3,572	85		85		3,572	12
13	OUTSIDE LIGHTS			1991	1,345					1,345	13
14	ROOF			1991	13,600					13,600	14
15	KITCHEN LIGHTS			1992	1,208					1,208	15
16	HAC UNITS			1992	26,114					26,114	16
17	ROOF			1992	9,000	450		450		8,400	17
18	HAC UNITS			1993	7,577					7,577	18
19	FENCE			1993	8,581	429		429		7,687	19
20	HAC UNITS			1993	2,023					2,023	20
21	HAC UNITS			1994	2,778					2,776	21
22	HAC UNITS			1994	2,124					2,124	22
23	HAC UNITS			1995	5,723					5,723	23
24	HAC UNITS			1996	4,050	135		135		4,050	24
25	REMODELING			1997	20,514	1,026		1,026		14,449	25
26	ROOF			1997	35,935					35,935	26
27	HAC UNITS			1997	3,375	225		225		2,963	27
28	PARKING LOT & DRAINAGE			1998	44,413	888		888		11,248	28
29	DUMPSTER			1998	1,931	97		97		1,228	29
30	ROOF			1998	3,800					3,800	30
31	FIRE ALARM SYSTEM			1999	48,588	2,429		2,429		28,136	31
32	KITCHEN REMODELING			2000	7,307	365		365		4,044	32
33	METAL CANOPY			2000	3,507	175		175		1,984	33
34	ROOM NUMBERS & NAME PLATED			2000	1,472	73		73		827	34
35	LANDSCAPING			2000	1,411	71		71		793	35
36	FIRE SHUTTERS & BASEBOARDS			2001	6,991	583		583		6,991	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, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 137	$	$ 1,381	37
38	EMERGENCY POWER SUPPLY	2001	54,674	2,734		2,734		27,112	38
39	WINDOWS	2001	11,446	572		572		5,530	39
40	CABINETS	2002	3,174	159		159		1,471	40
41	HAC UNITS	2002	4,030	269		269		2,555	41
42	WATER HEATER	2003	3,470	174		174		1,479	42
43	ROOF	2004	34,230	1,712		1,712		13,410	43
44	WINDOWS	2004	4,308	215		215		1,577	44
45	AC UNIT	2004	638	64		64		506	45
46	AC UNIT	2004	3,000	200		200		1,433	46
47	BATHROOM RAILS	2004	344	17		17		120	47
48	COURTYARD	2005	33,997	1,700		1,700		11,617	48
49	BATHROOM REMODELING	2005	19,729	986		986		6,656	49
50	ROOF	2005	12,600	1,260		1,260		8,820	50
51	AC UNIT	2005	1,079	72		72		456	51
52	ELECTRICAL IMPROVEMENTS	2006	11,050	737		737		4,299	52
53	DOOR	2006	1,750	117		117		643	53
54	HAC UNITS	2006	5,075	338		338		1,887	54
55	HAC UNITS	2008	6,426	428		428		1,177	55
56	FLOOR TILING	1985	4,671					4,671	56
57	DOORS & SPRINKLERS	1988	4,116					4,116	57
58	SINK	1990	852					852	58
59	RENTAL HOUSE	2011	28,954	351		351		351	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)		$ 1,858,387	$ 22,809		$ 22,809	$	$ 1,525,715	70

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

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 389,515	$ 32,897	$ 32,897	$		$ 222,112	71
72	Current Year Purchases	15,688	1,119	1,119		15 YRS	1,119	72
73	Fully Depreciated Assets	211,276					211,276	73
74								74
75	TOTALS	$ 616,479	$ 34,016	$ 34,016	$		$ 434,507	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	98 FORD VAN	1999	$ 26,198	$	$	$		$ 26,198	76
77	TRANSPORT RESIDENTS	2000 FIRD VAN	2009	8,002	1,600	1,600			4,267	77
78	TRANSPORT RESIDENTS	2008 FORD VAN	2010	34,803	5,801	5,801			9,185	78
79										79
80	TOTALS			$ 69,003	$ 7,401	$ 7,401	$		$ 39,650	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)	$ 2,566,014	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 64,226	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,226	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)	$ 1,999,872	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	BUILDING ADDITION	$ 78,559	92
93			93
94			94
95		$ 78,559	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.

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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.

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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, INC

STATE OF ILLINOIS
002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$	5,256	$ 78,157	$	5,256	$ 78,157	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		129	8,308		129	8,308	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		1,558	89,569		1,558	89,569	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				26,133			26,133	12
13	Other (specify): DRUGS & MED SUPP	39-2					89,099		89,099	13
14	TOTAL			$	6,943	$ 202,167	$ 89,099	6,943	$ 291,266	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.

STATE OF ILLINOIS

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06-30-2011 (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	$ 1,404,840	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (30,817))	326,237		3
4	Supply Inventory (priced at COST)	12,719		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,389		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): EMPLOYEE LOANS	5,650		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,778,835	$	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	1,936,946		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	685,482		16
17	Accumulated Depreciation (book methods)	(1,999,872)		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)**	$ 644,701	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,423,536	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,825	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,828		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,167		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,973		32
33	Accrued Interest Payable	1,505		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,414		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 342,712	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	154,396		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)**	$ 154,396	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 497,108	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,926,428	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,423,536	$	48

*(See instructions.)

Facility Name & ID Number FOUNTAINVIEW, INC **#** 002-0628 **Report Period Beginning:** 07-01-2010 **Ending:** 06-30-2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,028,678	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,028,678	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	552,647	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	(460,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PURCHASE OF TREASURY STOCK	(194,397)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (102,250)	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)**	$ 1,926,428	24 *

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

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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	$ 3,920,515	1
2	Discounts and Allowances for all Levels	52,723	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,973,238	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		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,270	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,000	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)**	$ 4,270	23
	D. Non-Operating Revenue		
24	Contributions	181	24
25	Interest and Other Investment Income***	7,949	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,130	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	3,418	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,418	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,989,056	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	764,973	31
32	Health Care	1,535,858	32
33	General Administration	669,260	33
	B. Capital Expense		
34	Ownership	106,747	34
	C. Ancillary Expense		
35	Special Cost Centers	298,798	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)***	$ 3,436,409	40
41	**Income before Income Taxes (line 30 minus line 40)****	552,647	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 552,647	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 FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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	$ 72,011	$ 34.62	1
2	Assistant Director of Nursing	1,664	1,752	45,284	25.85	2
3	Registered Nurses	8,598	8,992	189,825	21.11	3
4	Licensed Practical Nurses	24,716	25,751	423,387	16.44	4
5	CNAs & Orderlies	58,965	60,944	565,671	9.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,874	4,042	36,038	8.92	8
9	Activity Director					9
10	Activity Assistants	6,004	6,265	67,686	10.80	10
11	Social Service Workers	3,832	3,917	45,062	11.50	11
12	Dietician					12
13	Food Service Supervisor	1,958	2,054	21,587	10.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,857	14,365	124,081	8.64	15
16	Dishwashers					16
17	Maintenance Workers	2,125	2,265	36,398	16.07	17
18	Housekeepers	12,824	13,434	118,045	8.79	18
19	Laundry	6,409	6,641	56,673	8.53	19
20	Administrator	2,000	2,080	69,026	33.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,790	6,048	86,950	14.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,089	1,197	11,937	9.97	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTITIAN	579	734	7,532	10.26	33
34	TOTAL (lines 1 - 33)	156,284	162,561	$ 1,977,193 *	$ 12.16	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	$ 10,777	1/3	35
36	Medical Director	12	500	9/3	36
37	Medical Records Consultant	38	1,947	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,290	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	70	5,334	12/3	45
46	Other(specify) MDS CHARTING		8,510	10/3	46
47	SOUTHERN IL SMALL BUS.		2,800	10/3	47
48					48
49	TOTAL (lines 35 - 48)	324	$ 31,158		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

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEVE JOHNSON	ADMINISTRATOR	NONE	$ 69,026
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 69,026

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
HENSON	ACCOUNTING	$ 6,892
JAMESTOWN	ACCOUNTING	5,612
TOM WOLF	LEGAL	6,090
BILLY JONES	MANAGEMENT	34,600
LISA BERRY	FINANCIALS	480
LEWIS RICE	LEGAL	107
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 53,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,740
Unemployment Compensation Insurance	32,353
FICA Taxes	147,177
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT	15,010
CHRISTMAS PARTY & GIFTS	2,465
UNIFORM ALLOWANCE	2,575
TOTAL (agree to Schedule V, line 22, col.8)	$ 319,320

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,371
Advertising: Employee Recruitment	2,682
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
FLOWERS & RELATIONS	2,260
YELLOW PAGES	5,206
ANNUAL FEE	250
Less: Public Relations Expense	(2,260)
Non-allowable advertising	( )
Yellow page advertising	(5,206)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,303

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
LOCAL AUTO REIMBURSEMENT	10,337
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,337

**See instructions.

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 Report Period Beginning: 07-01-2010 Ending: 06-30-2011

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FOUNTAINVIEW, INC # 002-0628 **Report Period Beginning:** 07-01-2010 **Ending:** 06-30-2011

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? NO
If YES, give association name and amount.

(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? 15 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 20,352 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. $ 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 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? 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 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. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name:

(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? YES
Attach invoices and a summary of services for all architect and appraisal fees.