FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 ST (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 07-01-12 to 06-30-13 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) RHONDA TRAVELSTEAD
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (Date)
(Print Name and Title) STEPHANI MCCAUGHAN, VICE PRESIDENT OF OPERATIONS
(Firm Name & Address) JAMESTOWN MANAGEMENT CORPORATION, 1001 E. MAIN BLDG 4A, 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: 07-01-12 Ending: 06-30-13

III. STATISTICAL DATA

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

	1 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			2,875	2,875	8
9	SNF/PED					9
10	ICF	19,143	12,056		31,199	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,143	12,056	2,875	34,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.10%

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 2,875

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12-31-13 Fiscal Year: 06-30-2013

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	144,657	11,165	7,706	163,528		163,528		163,528			1
2	Food Purchase		178,838		178,838		178,838	(1,225)	177,613			2
3	Housekeeping	115,855	17,663		133,518		133,518		133,518			3
4	Laundry	50,518	7,929		58,447		58,447		58,447			4
5	Heat and Other Utilities			86,161	86,161		86,161		86,161			5
6	Maintenance	28,486	14,009	61,121	103,616		103,616		103,616			6
7	Other (specify):*											7
8	**TOTAL General Services**	339,516	229,604	154,988	724,108		724,108	(1,225)	722,883			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,249,134	56,029	2,677	1,307,840		1,307,840		1,307,840			10
10a	Therapy	36,845		3,334	40,179		40,179		40,179			10a
11	Activities	56,029	3,290		59,319		59,319		59,319			11
12	Social Services	44,171		5,107	49,278		49,278		49,278			12
13	CNA Training											13
14	Program Transportation			3,824	3,824		3,824		3,824			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,386,179	59,319	14,942	1,460,440		1,460,440		1,460,440			16
	C. General Administration											
17	Administrative	111,143			111,143		111,143		111,143			17
18	Directors Fees			20,950	20,950		20,950		20,950			18
19	Professional Services			50,759	50,759		50,759		50,759			19
20	Dues, Fees, Subscriptions & Promotions			12,762	12,762		12,762	(6,521)	6,241			20
21	Clerical & General Office Expenses	34,620	9,028	32,424	76,072		76,072	(24,907)	51,165			21
22	Employee Benefits & Payroll Taxes			302,669	302,669		302,669		302,669			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,385	6,385		6,385		6,385			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,682	53,682		53,682		53,682			26
27	Other (specify):*											27
28	**TOTAL General Administration**	145,763	9,028	479,631	634,422		634,422	(31,428)	602,994			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,871,458	297,951	649,561	2,818,970		2,818,970	(32,653)	2,786,317			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 #0020628 **Report Period Beginning:** 07-01-12 **Ending:** 06-30-13

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			91,829	91,829		91,829	(1,053)	90,776			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,655	2,655		2,655	(2,655)				32
33	Real Estate Taxes			35,644	35,644		35,644	(1,672)	33,972			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			130,128	130,128		130,128	(5,380)	124,748			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,937	236,476	345,413		345,413		345,413			39
40	Barber and Beauty Shops		931		931		931		931			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			203,230	203,230		203,230		203,230			42
43	Other (specify):* CHAPLIN	3,462			3,462		3,462		3,462			43
44	**TOTAL Special Cost Centers**	3,462	109,868	439,706	553,036		553,036		553,036			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,874,920	407,819	1,219,395	3,502,134		3,502,134	(38,033)	3,464,101			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 # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

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	(2,655)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,225)	2		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	(775)	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	(13,885)	21		24
25	Fund Raising, Advertising and Promotional	(1,396)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,247)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,125)	20		28
29	Other-Attach Schedule SEE PG 5A	(2,725)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,033)		$	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))**	$ (38,033)		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

ID# 0020628

Report Period Beginning: 07-01-12

Ending: 06-30-13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	REAL ESTATE TAX ON RENTAL	$ (1,672)	33	1
2	RENTAL DEPRECIATION	(1,053)	30	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**	(2,725)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-12 **Ending:** 06-30-13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,225)	0	0	0	0	0	0	0	0	0	0	(1,225)	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**	(1,225)	0	0	0	0	0	0	0	0	0	0	(1,225)	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	(6,521)	0	0	0	0	0	0	0	0	0	0	(6,521)	20
21	Clerical & General Office Expenses	(24,907)	0	0	0	0	0	0	0	0	0	0	(24,907)	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**	(31,428)	0	0	0	0	0	0	0	0	0	0	(31,428)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,653)	0	0	0	0	0	0	0	0	0	0	(32,653)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-12 **Ending:** 06-30-13

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	(1,053)	0	0	0	0	0	0	0	0	0	0	(1,053)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,655)	0	0	0	0	0	0	0	0	0	0	(2,655)	32
33	Real Estate Taxes	(1,672)	0	0	0	0	0	0	0	0	0	0	(1,672)	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**	(5,380)	0	0	0	0	0	0	0	0	0	0	(5,380)	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)**	(38,033)	0	0	0	0	0	0	0	0	0	0	(38,033)	45

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

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 MORGAN	7.57	POPE COUNTY CARE CENTER	GOLCONDA			
ALFERT G. BLEDIG	30.81					
DON R. DEARMON	26.49					
BILLY L. JONES	19.07					
EVERETT KNIGHT	8.86					
MARK W. KNIGHT	7.20					

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: 07-01-12 Ending: 06-30-13

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 # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

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	ALFRET G. BLEDIG	PRESIDENT	EXEC BOARD	30.81	NONE	2		DIR FEES	$ 3,950	18/3	1
2	DON R. DEARMON	DIRECTOR	EXEC BOARD	26.49	NONE	2		DIR FEES	1,200	18/3	2
3	BILLY L. JONES	SEC / TREAS	EXEC BOARD	19.07	NONE	2		DIR FEES	4,200	18/3	3
4	BILLY L. JONES	BUS MANAGER	MANAGE FACIL	19.07	NONE	18		BUS MGR	34,900	19/3	4
5	EVERETT KNIGHT	DIRECTOR	EXEC BOARD	8.86	NONE	2		DIR FEES	4,200	18/3	5
6	ROBERT MORGAN	DIRECTOR	EXEC BOARD	7.57	NONE	2		DIR FEES	3,450	18/3	6
7	MARK W. KNIGHT	VICE PRES	EXEC BOARD	7.20	NONE	2		DIR FEES	3,950	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,850		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: 07-01-12 Ending: 06-30-13

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: 07-01-12 Ending: 06-30-13

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	78,689	01/01/16	0.0150	2,655	6
7												7
8												8
9	TOTAL Facility Related						$ 200,000	$ 78,689			$ 2,655	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	$ 78,689			$ 2,655	15

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

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

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-12 **Ending:** 06-30-13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 64,043	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.)		$ 39,089	2
3. Under or (over) accrual (line 2 minus line 1).		$ (24,954)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,598	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.		$ 35,644	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	36,834	8
	2009	37,472	9
	2010	37,477	10
	2011	39,087	11
	2012	38,837	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-1-159-04	FACILITY 7.89 ACRES	$ 37,066.50	$ 37,066.50
2.	04-2-095-06	FACILITY ADDL LOT	$ 98.70	$ 98.70
3.	04-1-137-14	RENTAL HOUSE	$ 1,671.84	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,837.04	$ 37,165.20

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,659 B. General Construction Type: Exterior MASONRY 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: 07-01-12 Ending: 06-30-13

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	50	3,182		63,903	7
8			1998	1998	17,723	354	50	354		5,193	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					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	150	20	150		9,000	17
18	HAC UNITS			1993	7,577					7,577	18
19	FENCE			1993	8,581	429	20	429		8,545	19
20	HAC UNITS			1993	2,023					2,023	20
21	J			1994	2,778					2,778	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					4,050	24
25	REMODELING			1997	20,514	1,026	20	1,026		16,501	25
26	ROOF			1997	35,935					35,935	26
27	HAC UNITS			1997	3,375	187	15	187		3,375	27
28	PARKING LOT & DRAINAGE			1998	44,413	888	50	888		13,024	28
29	DUMPSTER			1998	1,931	97	20	97		1,422	29
30	ROOF			1998	3,800					3,800	30
31	FIRE ALARM SYSTEM			1999	48,588	2,429	20	2,429		32,994	31
32	KITCHEN REMODEING			2000	7,307	365	20	365		4,774	32
33	RETAL CANOPY			2000	3,507	175	20	175		2,334	33
34	ROOM NUMBERS & NAME PLATES			2000	1,472	73	20	73		973	34
35	LANDSCAPING			2000	1,411	71	20	71		935	35
36	FIRE SHUTTER & BASEBOARDS			2001	6,991					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 # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

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	15	$ 137	$	$ 1,655	37
38	EMERGENCY POWER SUPPLY	2001	54,674	2,734	20	2,734		32,580	38
39	WINDOWS	2001	11,446	572	20	572		6,674	39
40	CABINETS	2002	3,174	159	20	159		1,789	40
41	HAC UNITS	2002	4,030	269	20	269		3,093	41
42	WATER HEATER	2003	3,470	174	20	174		1,827	42
43	ROOF	2004	34,230	1,712	20	1,712		16,832	43
44	WINDOWS	2004	4,308	215	20	215		2,007	44
45	AC UNIT	2004	638	64	10	64		634	45
46	AC UNIT	2004	3,000	200	15	200		1,833	46
47	BATHROOM RAILS	2004	344	17	20	17		154	47
48	COURTYARD	2005	33,997	1,700	20	1,700		15,017	48
49	BATHROOM REMODELING	2005	19,729	986	20	986		8,628	49
50	ROOF	2005	12,600	1,260	10	1,260		11,340	50
51	AC UNIT	2005	1,079	72	15	72		600	51
52	ELECTRICAL IMPROVEMENTS	2006	11,050	737	15	737		5,773	52
53	DOOR	2006	1,750	117	15	117		877	53
54	HAC UNITS	2006	5,075	338	15	338		2,563	54
55	HAC UNITS	2008	6,426	428	15	428		2,033	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	SUN ROOM	2012	131,606	3,375	40	3,375		6,187	59
60	AC UNIT	2012	5,940	396	15	396		495	60
61	A/C UNIT	2012	5,940	231	15	231		231	61
62	VENTILATION SYSTEM	2012	373,025	20,557	15	20,557		20,557	62
63	SPRINKLER SYSTEM	2012	107,256	5,313	10	5,313		5,313	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,453,200	$ 51,189		$ 51,189	$	$ 1,601,119	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: 07-01-12 Ending: 06-30-13

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	$ 399,754	$ 31,500	$ 31,500	$	varies	$ 255,223	71
72	Current Year Purchases	20,675	686	686		varies	686	72
73	Fully Depreciated Assets	245,968					245,968	73
74								74
75	TOTALS	$ 666,397	$ 32,186	$ 32,186	$		$ 501,877	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 FORD VAN	2009	8,002	1,600	1,600		5	7,467	77
78	TRANSPORT RESIDENTS	2008 FORD VAN	2010	34,803	5,801	5,801		6	20,787	78
79										79
80	TOTALS			$ 69,003	$ 7,401	$ 7,401	$		$ 54,452	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)	$ 3,210,745	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 90,776	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,776	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)	$ 2,157,448	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	RENTAL HOUSE	$ 28,954	$ 1,053	$ 2,457	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 28,954	$ 1,053	$ 2,457	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.

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2014	$
13.	/2015	$
14.	/2016	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ N/A 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 # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

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 ONLY HIRE TRAINED AIDES

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: 07-01-12 Ending: 06-30-13

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	$	5,254	$ 93,121	$	5,254	$ 93,121	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		286	17,538		286	17,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		1,700	101,982	133	1,700	102,115	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				23,835			23,835	12
13	Other (specify): DRUGS & MED SUP	39/2					108,804		108,804	13
14	TOTAL			$	7,240	$ 236,476	$ 108,937	7,240	$ 345,413	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 # 0020628 Report Period Beginning: 07-01-12 Ending: 06-30-13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06-30-13 (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	$ 1,194,042	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	807,968		3
4	Supply Inventory (priced at COST)	15,291		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,627		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,039,928	$	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	2,495,180		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	725,762		16
17	Accumulated Depreciation (book methods)	(2,158,387)		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)**	$ 1,084,700	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,124,628	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,299	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,990		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,384		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,598		32
33	Accrued Interest Payable	761		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 476,032	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,689		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)**	$ 78,689	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 554,721	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,569,907	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,124,628	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,977,178	1	
2	Restatements (describe):		2	
3	PRIOR YEAR MEDICARE ADJUSTMENT	38,832	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,016,010	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	673,897	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	(120,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 553,897	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)**	$ 2,569,907	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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,976,693	1
2	Discounts and Allowances for all Levels	184,312	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,161,005	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		13
14	Non-Patient Meals		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,045	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,045	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	4,958	28
28a	MISCELLANEOUS INCOME	23	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,981	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,176,031	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	724,108	31
32	Health Care	1,460,440	32
33	General Administration	634,422	33
	B. Capital Expense		
34	Ownership	130,128	34
	C. Ancillary Expense		
35	Special Cost Centers	345,413	35
36	Provider Participation Fee	203,230	36
	D. Other Expenses (specify):		
37	BEAUTY SHOP	931	37
38	CHAPLIN	3,462	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,502,134	40
41	**Income before Income Taxes (line 30 minus line 40)****	673,897	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 673,897	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,687,505	44
45	Private Pay - Net Inpatient Revenue	1,334,949	45
46	Medicare - Net Inpatient Revenue	1,138,551	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,161,005	49

* **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	2,020	2,128	$ 58,183	$ 27.34	1
2	Assistant Director of Nursing	2,000	2,080	47,198	22.69	2
3	Registered Nurses	6,213	6,526	156,888	24.04	3
4	Licensed Practical Nurses	24,163	25,345	415,979	16.41	4
5	CNAs & Orderlies	54,580	56,496	544,377	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,600	3,862	36,845	9.54	8
9	Activity Director					9
10	Activity Assistants	5,327	5,688	56,029	9.85	10
11	Social Service Workers	3,829	3,965	44,171	11.14	11
12	Dietician					12
13	Food Service Supervisor	1,971	2,051	27,188	13.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,892	13,506	117,469	8.70	15
16	Dishwashers					16
17	Maintenance Workers	1,644	1,877	28,486	15.18	17
18	Housekeepers	11,529	12,174	115,855	9.52	18
19	Laundry	5,199	5,530	50,518	9.14	19
20	Administrator	1,960	2,152	57,096	26.53	20
21	Assistant Administrator	1,960	2,080	54,047	25.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,844	1,859	34,620	18.62	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	2,390	2,459	26,509	10.78	31
32	Other Health Care(specify)					32
33	Other(specify) CHAPLIN	321	321	3,462	10.79	33
34	TOTAL (lines 1 - 33)	143,442	150,099	$ 1,874,920 *	$ 12.49	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	72	$ 5,107	1/3	35
36	Medical Director				36
37	Medical Records Consultant	32	1,637	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,040	10/3	39
40	Physical Therapy Consultant	30	3,334	10A/3	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	5,107	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	218	$ 16,225		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)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RHONDA TRAVELSTEAD	ADMINISTRATOR	0	$ 57,096
LORI PRITCHARD	ASST. ADMIN	0	54,047
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 111,143

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
JAMES HENSON	ACCOUNTING	$ 8,545
JAMESTOWN MGMT	ACCOUNTING	6,124
MARGELPEDDICORD	MEDICAID CONS.	650
LISA BERRY	CORP MINUTES	540
BILLY L. JONES	MANAGER	34,900
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 50,759

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,216
Unemployment Compensation Insurance	18,565
FICA Taxes	140,195
Employee Health Insurance	13,713
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE INSURANCE	1,992
RETIREMENT	14,521
UNIFORM ALLOWANCE	2,875
CHRISTMAS PARTY	2,212
DRUG TESTING	845
SAFETY & ATTENDANCE	985
30 YEAR EMPLOYEE GIFT	550
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,669

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	$ 2,538
Advertising: Employee Recruitment	2,292
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 105	1,050
YELLOW PAGE ADV (ELIM)	5,125
PUBLIC RELATIONS ADV(ELIM)	1,396
ANNUAL REPORT	361
Less: Public Relations Expense	( )
Non-allowable advertising	(1,396)
Yellow page advertising	(5,125)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,241

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SCHEDULE ATTACHED	6,385
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,385

* 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		$		$	$	$	$	$	$	$	$	$

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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? **7.5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,963** 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. $ **203,230**
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. $ **NONE**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

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

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

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