		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0020628

Facility Name: FOUNTAINVIEW

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

County: SALINE

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

IDPA ID Number: 37-1012053001

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07-01-2004 to 06-30-2005 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)	TREASURER
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	JAMES C. HENSON CPA PRESIDENT
	(Firm Name & Address)	JAMES HENSON, P.C. P.O. BOX 280, RIDGWAY IL 62979
	(Telephone)	618-272-3931 Fax # 618-272-7105

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	87	Intermediate (ICF)	87	31,755	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,636		1,933	3,569	8
9	SNF/PED					9
10	ICF	27,794	10,795		38,589	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,430	10,795	1,933	42,158	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.56%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 22 and days of care provided 1,931

Medicare Intermediary ADMINSTAR FEDERAL

IV. ACCOUNTING BASIS

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

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

Tax Year: 12-31-2005 Fiscal Year: 06-30-2005

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	137,664	7,853	10,145	155,662		155,662		155,662			1
2	Food Purchase		159,243		159,243		159,243	(400)	158,843			2
3	Housekeeping	101,151	23,049	400	124,600		124,600		124,600			3
4	Laundry	46,163	6,073	150	52,386		52,386		52,386			4
5	Heat and Other Utilities			73,877	73,877		73,877		73,877			5
6	Maintenance	30,628	14,469	41,601	86,698		86,698		86,698			6
7	Other (specify):* WASTE REMOVAL			4,482	4,482		4,482		4,482			7
8	TOTAL General Services	315,606	210,687	130,655	656,948		656,948	(400)	656,548			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,039,882	66,304	4,414	1,110,600	(548)	1,110,052		1,110,052			10
10a	Therapy	40,267	12	2,463	42,742		42,742		42,742			10a
11	Activities	62,223	1,927	841	64,991		64,991		64,991			11
12	Social Services	18,723		841	19,564		19,564		19,564			12
13	CNA Training											13
14	Program Transportation		1,414		1,414		1,414		1,414			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,161,095	69,657	8,559	1,239,311	(548)	1,238,763		1,238,763			16
	C. General Administration											
17	Administrative	83,964			83,964		83,964		83,964			17
18	Directors Fees			18,250	18,250		18,250		18,250			18
19	Professional Services			67,525	67,525		67,525		67,525			19
20	Dues, Fees, Subscriptions & Promotions			6,348	6,348		6,348	(4,110)	2,238			20
21	Clerical & General Office Expenses	55,684	9,680	13,474	78,838		78,838		78,838			21
22	Employee Benefits & Payroll Taxes			313,408	313,408		313,408		313,408			22
23	Inservice Training & Education			3,114	3,114		3,114		3,114			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation		1,414		1,414		1,414		1,414			25
26	Insurance-Prop.Liab.Malpractice			83,042	83,042		83,042	(15,590)	67,452			26
27	Other (specify):* IL REPLACEMENT TAX			6,624	6,624		6,624	(6,624)				27
28	TOTAL General Administration	139,648	11,094	511,785	662,527		662,527	(26,324)	636,203			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,616,349	291,438	650,999	2,558,786	(548)	2,558,238	(26,724)	2,531,514			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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: 07-01-2004 Ending: 06-30-2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,685	54,685		54,685	28,305	82,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			31,946	31,946		31,946		31,946			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,660	14,660		14,660		14,660			35
36	Other (specify):*											36
37	TOTAL Ownership			101,291	101,291		101,291	28,305	129,596			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					548	548		548			38
39	Ancillary Service Centers		63,804	63,437	127,241		127,241		127,241			39
40	Barber and Beauty Shops	17,722	348	50	18,120		18,120		18,120			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,913	73,913		73,913		73,913			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	17,722	64,152	137,400	219,274	548	219,822		219,822			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,634,071	355,590	889,690	2,879,351		2,879,351	1,581	2,880,932			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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 Reference	3 OHF 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	28,305	30		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	(400)	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				20
21	Owner or Key-Man Insurance	(15,590)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,624)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,110)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,581		$	30

OHF 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))**	$ 1,581		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		$ 548	10	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 548		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

FOUNTAINVIEW

ID# 0020628

Report Period Beginning: 07-01-2004

Ending: 06-30-2005

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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	(400)	0	0	0	0	0	0	0	0	0	0	(400)	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**	(400)	0	0	0	0	0	0	0	0	0	0	(400)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,110)	0	0	0	0	0	0	0	0	0	0	(4,110)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(15,590)	0	0	0	0	0	0	0	0	0	0	(15,590)	26
27	Other (specify):*	(6,624)	0	0	0	0	0	0	0	0	0	0	(6,624)	27
28	**TOTAL General Administration**	(26,324)	0	0	0	0	0	0	0	0	0	0	(26,324)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,724)	0	0	0	0	0	0	0	0	0	0	(26,724)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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	28,305	0	0	0	0	0	0	0	0	0	0	28,305	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**	28,305	0	0	0	0	0	0	0	0	0	0	28,305	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)**	1,581	0	0	0	0	0	0	0	0	0	0	1,581	45

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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	ALBRT G. BLEDIG	PRESIDENT	EXEC. BOARD	22.97		2		DIR. FEES	$ 3,000	18-3	1
2	DON R. DEARMON	SECRETARY	EXEC. BOARD	22.97		2		DIR. FEES	3,000	18-3	2
3	BILLY L. JONES	TREASURER	EXEC. BOARD	10.29		2		DIR. FEES	3,000	18-3	3
4	BILLY L. JONES	---	BUS. MANAGER	0.00		12		BUS. MGR.	25,400	19-3	4
5	EVERETT KNIGHT	DIRECTOR	EXEC. BOARD	5.83		2		DIR. FEES	3,000	18-3	5
6	ROBERT G. MORGAN	VICE PRESIDENT	EXEC. BOARD	6.56	*4800	2		DIR. FEES	3,000	18-3	6
7	JAMES B. CHILDRESS	DIRECTOR	EXEC. BOARD	13.12		2		DIR. FEES	3,000	18-3	7
8	DENTON FERRELL	DIRECTOR	EXEC. BOARD	0.00		0		DIR. FEES	250	18-3	8
9											9
10											10
11											11
12	* POPE COUNTY CARE CENTER, GOLCONDA, ILLINOIS										12
13								TOTAL	$ 43,650		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 6-30-2005

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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: 07-01-2004 Ending: 06-30-2005

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 46,494	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.)	$ 30,629	2
3. Under or (over) accrual (line 2 minus line 1).	$ (15,865)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 47,811	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.	$ 31,946	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000	27,428	8
2001	28,439	9
2002	29,568	10
2003	30,629	11
2004	31,559	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

LINE 2 - 2003 PAID 2004

LINE 4 - 2004 PAYABLE 2005 $31,559 + 1/2 2005 PAYABLE 2006 $16,252 = $47,811

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-1-159-04	FACILITY LOCATION 4.89 ACRES	$ 31,559.00	$ 31,559.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,559.00	$ 31,559.00

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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	217,800	1976	$ 21,500	1
2					2
3	TOTALS	217,800		$ 21,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	47		1976	1973	$ 324,614	$	27	$	$	$ 324,614	4
5	76		1976	1976	519,630		30	17,321	17,321	517,012	5
6	12		1983	1983	273,457		30	9,115	9,115	198,272	6
7			1993	1993	159,083	3,182	50	3,182		38,449	7
8			1998	1998	17,723	354	50	354		2,360	8
	Improvement Type**										
9	ROOF			1982	20,564		10			20,564	9
10	ROOF			1988	14,123		10			14,123	10
11	ROOF			1990	10,586		10			10,586	11
12	LIFT			1991	3,572	179	10		(179)	3,572	12
13	OUTSIDE LIGHTS			1991	1,345		10			1,345	13
14	ROOF			1991	13,600		20	680	680	9,350	14
15	KITCHEN LIGHTS			1992	1,208		20	60	60	795	15
16	HEATING & AIR UNITS			1992	26,114	1,741	15	1,741		22,343	16
17	ROOF			1992	9,000	450	20	450		5,700	17
18	HEATING & AIR UNITS			1993	7,578	505	15	505		6,144	18
19	FENCE			1993	8,581	429	20	429		5,112	19
20	HEATING & AIR UNITS			1993	2,023	135	15	135		1,597	20
21	HEATING & AIR UNITS			1994	2,777	185	15	185		2,220	21
22	HEATING & AIR UNITS			1994	2,124	142	15	142		1,574	22
23	HEATING & AIR UNITS			1995	5,723	382	15	382		3,947	23
24	HEATING & AIR UNITS			1996	4,050	270	15	270		2,565	24
25	REMODELING			1997	20,514	1,026	30	684	(342)	5,529	25
26	ROOF			1997	35,935	4,704	7	4,703	(1)	35,935	26
27	AIR CONDITIONING UNIT			1997	3,375	225	15	225		1,613	27
28	PARKING LOT & DRAINAGE			1998	44,413	888	50	888		5,920	28
29	DUMPSTER			1998	1,931	97	20	97		645	29
30	ROOF			1998	3,800	543	7	543		3,620	30
31	FIRE ALARM SYSTEM			1999	48,588	2,429	20	2,429		13,562	31
32	KITCHEN REMODELING			2000	7,307	365	20	365		1,855	32
33	METAL CANOPY			2000	3,508	175	20	175		933	33
34	ROOM NUMBERS & NAME PLATES			2000	1,472	73	20	73		389	34
35	LANDSCAPING			2000	1,411	71	20	71		367	35
36	FIRE SUTTERS & BASEBOARDS			2001	6,991	699	10	699		2,913	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HEATERS	2001	$ 2,054	$ 137	15	$ 137	$	$ 559	37
38	EMERGENCY POWER SUPPLY	2001	54,674	2,734	20	2,734		10,708	38
39	WINDOWS	2001	11,446	572	20	572		2,098	39
40	CABINETS	2002	3,174	159	20	159		517	40
41	HEATING & AIR UNIT	2002	4,030	269	15	269		941	41
42	WATER HEATER	2003	3,470	174	20	174		435	42
43	ROOF	2004	34,230	1,712	20	1,712		3,138	43
44	WINDOWS	2004	4,308	215	20	215		287	44
45	AIR CONDITIONING UNIT	2004	638	64	10	64		122	45
46	AIR CONDITIONING UNIT	2004	3,000	200	15	200		233	46
47	BATHROOM RAILS	2004	344	17	20	17		18	47
48	COURTYARD	2005	33,997	1,417	20	1,417		1,417	48
49	BATHROOM REMODELING	2005	19,729	740	20	740		740	49
50	ROOF	2005	12,600	1,260	10	1,260		1,260	50
51	AIR CONDITIONING UNIT	2005	1,079	24	15	24		24	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,795,493	$ 28,943		$ 55,597	$ 26,654	$ 1,288,022	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 452,796	$ 21,247	$ 22,898	$ 1,651		$ 258,804	71
72	Current Year Purchases	27,424	597	597			597	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 480,220	$ 21,844	$ 23,495	$ 1,651		$ 259,401	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	95 CHEVY VAN	1998	$ 12,775	$ 1,278	$ 1,278	$	10	$ 8,733	76
77	TRANSPORT RESIDENTS	98 FORD VAN	1999	26,198	2,620	2,620		10	14,399	77
78										78
79										79
80	TOTALS			$ 38,973	$ 3,898	$ 3,898	$		$ 23,132	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)	$ 2,336,186	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,685	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,990	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 28,305	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,570,555	85	

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

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

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SEE LETTER ATTACHED TO THIS REPORT
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.	/2006	$
13.	/2007	$
14.	/2008	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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.

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)	$			

(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.

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	

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39.2	hrs	$	373	$ 14,206	$	373	$ 14,206	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39.2	hrs		1,386	49,231		1,386	49,231	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts				44,632		44,632	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB, X-RAY, SUPPLI	39.3					19,172		19,172	13
14	TOTAL			$	1,759	$ 63,437	$ 63,804	1,759	$ 127,241	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06-30-2005 (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	$ 519,161	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance NONE)	671,276		3
4	Supply Inventory (priced at COST)	13,514		4
5	Short-Term Investments			5
6	Prepaid Insurance	36,837		6
7	Other Prepaid Expenses	5,500		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,246,288	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,500		13
14	Buildings, at Historical Cost	1,805,132		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	509,554		16
17	Accumulated Depreciation (book methods)	(1,667,956)		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)**	$ 668,230	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,914,518	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 68,705	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,351		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,595		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,811		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,475		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 251,937	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 251,937	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,662,581	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,914,518	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,641,207	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,641,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	421,374	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	(400,000)	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)**	$ 21,374	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)**	$ 1,662,581	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,295,002	1
2	Discounts and Allowances for all Levels	(8,861)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,286,141	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	2,192	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)**	$ 2,192	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,914	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,914	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	435	28
28a	REFUNDS & MISCELLANEOUS INCOME	4,043	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,478	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,300,725	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	656,948	31
32	Health Care	1,239,311	32
33	General Administration	662,527	33
	B. Capital Expense		
34	Ownership	101,291	34
	C. Ancillary Expense		
35	Special Cost Centers	145,361	35
36	Provider Participation Fee	73,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,879,351	40
41	**Income before Income Taxes (line 30 minus line 40)****	421,374	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 421,374	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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. SEE ACCOUNTANTS' COMPILATION REPORT

****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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,080	$ 45,257	$ 21.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,620	8,047	132,158	16.42	3
4	Licensed Practical Nurses	23,185	24,430	312,323	12.78	4
5	CNAs & Orderlies	66,596	70,211	532,806	7.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,112	4,394	40,267	9.16	8
9	Activity Director	1,947	2,075	21,576	10.40	9
10	Activity Assistants	4,833	5,045	40,647	8.06	10
11	Social Service Workers	1,948	2,087	18,723	8.97	11
12	Dietician					12
13	Food Service Supervisor	2,011	2,077	14,580	7.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,823	16,689	123,084	7.38	15
16	Dishwashers					16
17	Maintenance Workers	2,120	2,229	30,628	13.74	17
18	Housekeepers	12,443	13,315	101,151	7.60	18
19	Laundry	6,262	6,580	46,163	7.02	19
20	Administrator	1,976	2,080	52,004	25.00	20
21	Assistant Administrator	1,976	2,080	31,960	15.37	21
22	Other Administrative					22
23	Office Manager	1,936	2,080	29,648	14.25	23
24	Clerical	1,936	2,080	26,036	12.52	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	2,066	2,204	17,338	7.87	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTY SHOP	1,926	2,078	17,722	8.53	33
34	TOTAL (lines 1 - 33)	162,636	171,861	$ 1,634,071 *	$ 9.51	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 9,595	1-3	35
36	Medical Director				36
37	Medical Records Consultant	27	1,733	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		450	10-3	39
40	Physical Therapy Consultant	57	2,363	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	841	11-3	44
45	Social Service Consultant	15	841	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	$ 15,823		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ NONE		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
DENISE LUCKETT	ADM	0	52,004
ANITA VANN	ASST ADM	0	31,960
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 83,964

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ NONE

C. Professional Services

Vendor/Payee	Type	Amount
BILL JONES	BUSINESS MGR	$ 25,400
JAMESTOWN MANAGEMENT	ACCOUNTING SERV	3,163
JAMES HENSON, PC	ACCOUNTING SERV	5,310
LISA BERRY	SECRETARIAL/TYPING	360
LEWIS & RICE	ANNUAL REPORT	153
JAMES SMITH, PC	LEGAL	511
TOM WOLF	LEGAL	250
POIRER & ASSOCIATES	ARCHETECT FEES *	32,378
* FEES FOR DESIGN OF CONSTRUCTION PROJECTS THAT WERE CANCELLED BECAUSE BIDS WERE TOO HIGH		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 67,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,050
Unemployment Compensation Insurance	18,894
FICA Taxes	120,840
Employee Health Insurance	15,500
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT - SEP	12,947
EMPLOYEE X-MAS EXPENSE	1,486
EMPLOYEE VACCINES	1,884
EMPOYER LIFE INSURANCE	1,807
TOTAL (agree to Schedule V, line 22, col.8)	$ 313,408

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

Description	Line #	Amount
		$
TOTAL		$ NONE

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,628
Health Care Worker Background Check	720
(Indicate # of checks performed 45)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(4,110)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,238

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ NONE

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2004 Ending: 06-30-2005

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 YRS.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 30,699 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? NO YES 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. $ 73,913
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? N/A

(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? 50
d. Have vehicle usage logs been maintained? NO
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? N/A
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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(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 $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.