



Facility Name & ID Number FOUNTAINVIEW# 0020628 Report Period Beginning: 07-01-2007 Ending: 06-30-2008

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,738</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>82</u>	Intermediate (ICF)	<u>82</u>	<u>30,012</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>125</u>	TOTALS	<u>125</u>	<u>45,750</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	<u>362</u>		<u>2,877</u>	<u>3,239</u>	8
9	SNF/PED					9
10	ICF	<u>22,525</u>	<u>10,477</u>		<u>33,002</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,887</u>	<u>10,477</u>	<u>2,877</u>	<u>36,241</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 79.22%

D. How many bed-hold days during this year were paid by the Department?

2 (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)

NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 08-17-1976

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number  
of beds certified 43 and days of care provided 2,877Medicare Intermediary NATIONAL GOVERNMENT SERVICES

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12-31-2008 Fiscal Year: 06-30-2008

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

Facility Name & ID Number **FOUNTAINVIEW** # **0020628** Report Period Beginning: **07-01-2007** Ending: **06-30-2008**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	150,399	11,827	10,226	172,452		172,452	172,452			1
2	Food Purchase		176,954		176,954		176,954	176,954			2
3	Housekeeping	125,648	14,739		140,387		140,387	140,387			3
4	Laundry	51,953	11,088		63,041		63,041	63,041			4
5	Heat and Other Utilities			102,893	102,893		102,893	102,893			5
6	Maintenance	32,176	43,220	45,009	120,405		120,405	120,405			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>360,176</b>	<b>257,828</b>	<b>158,128</b>	<b>776,132</b>		<b>776,132</b>	<b>776,132</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000	3,000			9
10	Nursing and Medical Records	1,184,669	57,410	2,725	1,244,804		1,244,804	1,244,804			10
10a	Therapy	15,929			15,929		15,929	15,929			10a
11	Activities	53,392	2,608		56,000		56,000	56,000			11
12	Social Services	52,187		4,512	56,699		56,699	56,699			12
13	CNA Training										13
14	Program Transportation	7,218		4,801	12,019		12,019	12,019			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,313,395</b>	<b>60,018</b>	<b>15,038</b>	<b>1,388,451</b>		<b>1,388,451</b>	<b>1,388,451</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	60,962			60,962		60,962	60,962			17
18	Directors Fees			21,000	21,000		21,000	21,000			18
19	Professional Services			44,230	44,230		44,230	44,230			19
20	Dues, Fees, Subscriptions & Promotions			8,454	8,454		8,454	(4,889)	3,565		20
21	Clerical & General Office Expenses	65,205	8,982	36,381	110,568		110,568	(6,534)	104,034		21
22	Employee Benefits & Payroll Taxes			302,189	302,189		302,189	(7,480)	294,709		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,227	67,227		67,227	67,227			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>126,167</b>	<b>8,982</b>	<b>479,481</b>	<b>614,630</b>		<b>614,630</b>	<b>(18,903)</b>	<b>595,727</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,799,738</b>	<b>326,828</b>	<b>652,647</b>	<b>2,779,213</b>		<b>2,779,213</b>	<b>(18,903)</b>	<b>2,760,310</b>		<b>29</b>

\*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: 07-01-2007 Ending: 06-30-2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			56,065	56,065	56,065	7,480	63,545			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			35,756	35,756	35,756		35,756			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			8,463	8,463	8,463		8,463			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			100,284	100,284	100,284	7,480	107,764			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		81,974	199,033	281,007	281,007		281,007			39
40	Barber and Beauty Shops	15,028	1,237		16,265	16,265		16,265			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			68,626	68,626	68,626		68,626			42
43	Other (specify):* <b>GRANT EXPENSE</b>			4,093	4,093	4,093		4,093			43
44	<b>TOTAL Special Cost Centers</b>	15,028	83,211	271,752	369,991	369,991		369,991			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,814,766	410,039	1,024,683	3,249,488	3,249,488	(11,423)	3,238,065			45

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

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**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,480	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				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	(7,480)	22		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	(6,534)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,889)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (11,423)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (11,423)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

FOUNTAINVIEW

ID# 0020628

Report Period Beginning: 07-01-2007

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number FOUNTAINVIEW

# 0020628

Report Period Beginning:

07-01-2007

Ending:

06-30-2008

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	(4,889)	0	0	0	0	0	0	0	0	0	0	(4,889)	20
21	Clerical & General Office Expenses	(6,534)	0	0	0	0	0	0	0	0	0	0	(6,534)	21
22	Employee Benefits & Payroll Taxes	(7,480)	0	0	0	0	0	0	0	0	0	0	(7,480)	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	<b>TOTAL General Administration</b>	(18,903)	0	0	0	0	0	0	0	0	0	0	(18,903)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(18,903)	0	0	0	0	0	0	0	0	0	0	(18,903)	29

STATE OF ILLINOIS

Facility Name & ID Number FOUNTAINVIEW

# 0020628

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Summary B

06-30-2008

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	7,480	0	0	0	0	0	0	0	0	0	0	7,480	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	<b>TOTAL Ownership</b>	<b>7,480</b>	<b>0</b>	<b>7,480</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(11,423)</b>	<b>0</b>	<b>(11,423)</b>	<b>45</b>									

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# 0020628

Report Period Beginning: 07-01-2007 Ending: 06-30-2008

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT G. MORGAN	6.76	POPE COUNTY CARE CENTER	GOLCONDA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

Facility Name &amp; ID Number

FOUNTAINVIEW

#

0020628

Report Period Beginning:

07-01-2007

Ending:

06-30-2008

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALBERT G.. BLEDIG	PRESIDENT	EXEC. BOARD	23.66		2		DIR FEES	\$ 3,000	18-3	1
2	DON R. DEARMON	SECRETARY	EXEC. BOARD	23.66		2		DIR FEES	3,000	18-3	2
3	BILLY L. JONES	TREASURER	EXEC. BOARD	15.12		2		DIR FEES	3,000	18-3	3
4	BILLY L. JONES	BUS MANAGER				18		BUS MGR.	31,400	19-3	4
5	EVERETT KNIGHT	DIRECTOR	EXEC. BOARD	6.00		2		DIR FEES	3,000	18-3	5
6	ROBERT G. MORGAN	VICE PRESIDENT	EXEC. BOARD	6.76		2		DIR FEES	3,000	18-3	6
7	JAMES B CHILDRESS	DIRECTOR	EXEC. BOARD	13.52		2		DIR FEES	3,000	18-3	7
8	MARK W. KNIGHT	DIRECTOR	EXEC. BOARD	4.52		2		DIR FEES	3,000	18-3	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 52,400		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

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	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.)

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 52,347	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.)		\$ 35,326	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (17,021)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 52,777	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 35,756	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	30,629	8
	2004	31,559	9
	2005	34,895	10
	2006	34,897	11
	2007	35,326	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 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.

**2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-1-159-04</u>	<u>FACILITY LOCATION 4.89 ACRES</u>	\$ <u>35,231.32</u>	\$ <u>35,231.32</u>
2. <u>04-2-095-06</u>	<u>FACILITY LOCATION ADDL LOT</u>	\$ <u>94.24</u>	\$ <u>94.24</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>35,325.56</u>	\$ <u>35,325.56</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

07-01-2007 Ending:

06-30-2008

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>217,800</u>	<u>1976</u>	<u>\$ 21,500</u>	<u>1</u>
2	<u>FACILITY</u>	<u>5,000</u>	<u>2006</u>	<u>645</u>	<u>2</u>
3	<b>TOTALS</b>	<b>222,800</b>		<b>\$ 22,145</b>	<b>3</b>

Facility Name &amp; ID Number FOUNTAINVIEW

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42		1976	1976	\$ 324,614	\$	27	\$	\$	\$ 324,614	4
5	71		1976	1976	519,630		30			519,630	5
6	12		1983	1983	273,457		30	9,115	9,115	225,617	6
7			1993	1993	159,083	3,182	50	3,182		47,995	7
8			1998	1998	17,723	354	50	354		3,422	8
	<b>Improvement Type**</b>										
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	11,390	14
15	KITCHEN LIGHTS		1992		1,208		20	60	60	975	15
16	HAC UNITS		1992		26,114	1,741	15	289	(1,452)	26,114	16
17	ROOF		1992		9,000	450	20	450		7,050	17
18	HAC UNITS		1993		7,578	505	15	424	(81)	7,578	18
19	FENCE		1993		8,581	429	20	429		6,399	19
20	HAC UNITS		1993		2,023	135	15	135		2,002	20
21	HAC UNITS		1994		2,777	185	15	187	2	2,777	21
22	HAC UNITS		1994		2,124	142	15	142		2,000	22
23	HAC UNITS		1995		5,723	382	15	382		5,093	23
24	HAC UNITS		1996		4,050	270	15	270		3,375	24
25	REMODELING		1997		20,514	1,026	30	684	(342)	7,581	25
26	ROOF		1997		35,935		7			35,935	26
27	AC UNIT		1997		3,375	225	15	225		2,288	27
28	PARKING LOT & DRAINAGE		1998		44,413	888	50	888		8,584	28
29	DUMPSTER		1998		1,931	97	20	97		936	29
30	ROOF		1998		3,800		7			3,800	30
31	FIRE ALARM SYSTEM		1999		48,588	2,429	20	2,429		20,849	31
32	KITCHEN REMODELING		2000		7,307	365	20	365		2,950	32
33	METAL CANOPY		2000		3,508	175	20	175		1,458	33
34	ROOM NUMBERS & NAME PLATES		2000		1,472	73	20	73		608	34
35	LANDSCAPING		2000		1,411	71	20	71		580	35
36	FIRE SHUTTERS & BASEBOARDS		2001		6,991	699	10	699		5,010	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 &amp; ID Number FOUNTAINVIEW

# 0020628

Report Period Beginning:

07-01-2007 Ending:

06-30-2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HEATERS	2001	\$ 2,054	\$ 137	15	\$ 137	\$	\$ 970	37
38	EMERGENCY POWER SUPPLY	2001	54,674	2,734	20	2,734		18,910	38
39	WINDOWS	2001	11,446	572	20	572		3,814	39
40	CABINETS	2002	3,174	159	20	159		994	40
41	HAC UNITS	2002	4,030	269	15	269		1,748	41
42	WATER HEATER	2003	3,470	174	20	174		957	42
43	ROOF	2004	34,230	1,712	20	1,712		8,274	43
44	WINDOWS	2004	4,308	215	20	215		932	44
45	AC UNIT	2004	638	64	10	64		314	45
46	AC UNIT	2004	3,000	200	15	200		833	46
47	BATHROOM RAILS	2004	344	17	20	17		69	47
48	COURT YARD	2005	33,997	1,700	20	1,700		6,517	48
49	BATHROOM REMODELING	2005	19,729	986	20	986		3,698	49
50	ROOF	2005	12,600	1,260	10	1,260		5,040	50
51	AC UNIT	2005	1,079	72	15	72		240	51
52	ELECTRICAL IMPROVEMENTS	2006	11,050	737	15	737		2,088	52
53	DOOR	2006	1,750	117	15	117		292	53
54	HAC UNITS	2006	5,075	338	15	338		873	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)		\$ 1,813,368	\$ 25,465		\$ 33,268	\$ 7,803	\$ 1,393,363	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: 07-01-2007 Ending: 06-30-2008

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	\$ 404,839	\$ 25,135	\$ 25,135	\$	5-20 YRS	\$ 208,782	71
72	Current Year Purchases	25,744	1,567	1,567		5-10 YRS	1,567	72
73	Fully Depreciated Assets	131,335					131,335	73
74								74
75	TOTALS	\$ 561,918	\$ 26,702	\$ 26,702	\$		\$ 341,684	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	\$ 12,567	76
77	TRANSPORT RESIDENTS	98 FORD VAN	1999	26,198	2,620	2,620		10	22,259	77
78										78
79										79
80	TOTALS			\$ 38,973	\$ 3,898	\$ 3,898	\$		\$ 34,826	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)		\$ 2,436,404	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 56,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 63,868	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 7,803	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,769,873	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number FOUNTAINVIEW

# 0020628

Report Period Beginning: 07-01-2007

Ending: 06-30-2008

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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: \_\_\_\_\_\*

**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	<b>TOTAL</b>		\$ _____	\$ _____	21

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$	1,005	\$ 61,493	\$	1,005	\$ 61,493	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		204	14,782		204	14,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		1,545	91,035		1,545	91,035	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				77,091		77,091	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>LAB, XRAY, MED SUPPLIES</b>					31,723	4,883		36,606	13
14	<b>TOTAL</b>			\$	2,754	\$ 199,033	\$ 81,974	2,754	\$ 281,007	14

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

Facility Name & ID Number FOUNTAINVIEW# 0020628Report Period Beginning: 07-01-2007

Ending:

06-30-2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06-30-2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 616,509	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	718,692		3
4	Supply Inventory (priced at <u>COST</u> )	12,392		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,262		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>EMPLOYEE LOANS</u>	2,776		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,379,631	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,145		13
14	Buildings, at Historical Cost	1,823,007		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	591,253		16
17	Accumulated Depreciation (book methods)	(1,833,151)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 603,254	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,982,885	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 91,280	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,721		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,988		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,205		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 262,194	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 262,194	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,720,691	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,982,885	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,888,691	1
2	Restatements (describe):		2
3	<b>PRIOR PERIOD MEDICARE ADJUSTMENT</b>	13,717	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,902,408	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	393,283	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	(450,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <b>PURCHASE TREASURY STOCK</b>	(125,000)	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (181,717)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,720,691	24 *

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

Facility Name &amp; ID Number FOUNTAINVIEW

# 0020628

Report Period Beginning: 07-01-2007

Ending: 06-30-2008

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,572,344	1
2	Discounts and Allowances for all Levels	25,069	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,597,413	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	7,392	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,334	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 10,726	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	31,892	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 31,892	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING INCOME</b>	354	28
28a	<b>MISCELLANEOUS</b>	2,386	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,740	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,642,771	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	776,132	31
32	Health Care	1,388,451	32
33	General Administration	614,630	33
<b>B. Capital Expense</b>			
34	Ownership	100,284	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	301,365	35
36	Provider Participation Fee	68,626	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,249,488	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	393,283	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 393,283	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **FOUNTAINVIEW**

# **0020628**

Report Period Beginning: **07-01-2007**

Ending:

**06-30-2008**

**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	1,960	2,080	\$ 60,209	\$ 28.95	1
2	Assistant Director of Nursing	1,960	2,080	38,760	18.63	2
3	Registered Nurses	6,929	7,368	144,582	19.62	3
4	Licensed Practical Nurses	24,209	25,230	373,876	14.82	4
5	CNAs & Orderlies	61,379	64,078	543,576	8.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,326	1,500	15,929	10.62	8
9	Activity Director	1,915	1,963	17,822	9.08	9
10	Activity Assistants	3,736	3,901	35,570	9.12	10
11	Social Service Workers	3,754	3,947	52,187	13.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,113	2,234	26,704	11.95	14
15	Cook Helpers/Assistants	15,023	15,810	123,695	7.82	15
16	Dishwashers					16
17	Maintenance Workers	2,022	2,153	32,176	14.94	17
18	Housekeepers	13,531	14,628	125,648	8.59	18
19	Laundry	6,130	6,431	51,953	8.08	19
20	Administrator	2,080	2,080	60,962	29.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,080	33,262	15.99	23
24	Clerical	1,960	2,080	31,943	15.36	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	2,585	1,704	23,666	13.89	31
32	Other Health Care TRANSPORTATI	905	905	7,218	7.98	32
33	Other(specify) BEAUTY SHOP	1,479	1,583	15,028	9.49	33
34	TOTAL (lines 1 - 33)	156,956	163,835	\$ 1,814,766 *	\$ 11.08	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	195	\$ 10,226	1-3	35
36	Medical Director	24	3,000	9-3	36
37	Medical Records Consultant	31	1,584	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,141	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	66	4,512	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	340	\$ 20,463		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)		\$		53





**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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,688 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 NO 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. \$ 68,626  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? NONE Indicate the amount. \$ NONE
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.