

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0020628</u></p> <p>Facility Name: <u>FOUNTAINVIEW</u></p> <p>Address: <u>1001 A JEFFERSON STREET</u> <u>ELDORADO</u> <u>62930</u> <small>Number City Zip Code</small></p> <p>County: <u>SALINE</u></p> <p>Telephone Number: <u>618-273-3353</u> Fax # <u>618-273-4800</u></p> <p>HFS ID Number: <u>37-1012053001</u></p> <p>Date of Initial License for Current Owners: <u>08-17-1976</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BILLY L. JONES</u> Telephone Number: <u>618-273-3353</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07-01-2008</u> to <u>06-30-2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Type or Print Name) <u>BILLY L. JONES</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Title) <u>MANAGER</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Print Name and Title) <u>ROGER W. BAGLEY</u> <u>VICE-PRESIDENT</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Firm Name & Address) <u>JAMESTOWN MANAGEMENT CORPOATION</u> <u>1001 E. MAIN, CARBONDALE, IL</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Telephone) <u>618-549-8331</u> Fax # <u>618-549-0133</u></td> <td style="border: none;"></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>BILLY L. JONES</u>		(Title) <u>MANAGER</u>		Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>ROGER W. BAGLEY</u> <u>VICE-PRESIDENT</u>		(Firm Name & Address) <u>JAMESTOWN MANAGEMENT CORPOATION</u> <u>1001 E. MAIN, CARBONDALE, IL</u>		(Telephone) <u>618-549-8331</u> Fax # <u>618-549-0133</u>	
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Facility Name & ID Number FOUNTAINVIEW

0020628 Report Period Beginning: 07-01-2008 Ending: 06-30-2009

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>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>82</u>	Intermediate (ICF)	<u>82</u>	<u>29,930</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>45,625</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>371</u>		<u>3,195</u>	<u>3,566</u>	8
9	SNF/PED					9
10	ICF	<u>18,459</u>	<u>13,596</u>		<u>32,055</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,830</u>	<u>13,596</u>	<u>3,195</u>	<u>35,621</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.07%

D. How many bed-hold days during this year were paid by the Department? 1 (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

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 38 and days of care provided 3,195

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12-31-2009 Fiscal Year: 06-30-2009

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

Facility Name & ID Number

FOUNTAINVIEW

0020628

Report Period Beginning:

07-01-2008

Ending:

06-30-2009

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
	A. General Services										
1	Dietary	134,421	11,744	10,497	156,662		156,662	156,662			1
2	Food Purchase		168,530		168,530		168,530	168,530			2
3	Housekeeping	123,604	14,530		138,134		138,134	138,134			3
4	Laundry	54,823	9,421		64,244		64,244	64,244			4
5	Heat and Other Utilities			100,542	100,542		100,542	100,542			5
6	Maintenance	34,547	32,450	53,363	120,360		120,360	120,360			6
7	Other (specify):*										7
8	TOTAL General Services	347,395	236,675	164,402	748,472		748,472	748,472			8
	B. Health Care and Programs										
9	Medical Director			750	750		750	750			9
10	Nursing and Medical Records	1,269,706	69,010	2,813	1,341,529		1,341,529	1,341,529			10
10a	Therapy										10a
11	Activities	61,102	2,345		63,447		63,447	63,447			11
12	Social Services	39,316		4,875	44,191		44,191	44,191			12
13	CNA Training										13
14	Program Transportator			3,883	3,883		3,883	3,883			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,370,124	71,355	12,321	1,453,800		1,453,800	1,453,800			16
	C. General Administration										
17	Administrative	65,049			65,049		65,049	65,049			17
18	Directors Fees			21,000	21,000		21,000	21,000			18
19	Professional Services			46,391	46,391		46,391	46,391			19
20	Dues, Fees, Subscriptions & Promotion			9,748	9,748		9,748	9,748			20
21	Clerical & General Office Expenses	66,529	9,976	25,415	101,920		101,920	(10,709)	91,211		21
22	Employee Benefits & Payroll Taxes			301,131	301,131		301,131	(7,480)	293,651		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportator										25
26	Insurance-Prop.Liab.Malpractice			71,750	71,750		71,750	71,750			26
27	Other (specify):*										27
28	TOTAL General Administration	131,578	9,976	475,435	616,989		616,989	(18,189)	598,800		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,849,097	318,006	652,158	2,819,261		2,819,261	(18,189)	2,801,072		29

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

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

Facility Name & ID Number

FOUNTAINVIEW

#0020628

Report Period Beginning:

07-01-2008

Ending:

06-30-2009

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	
	D. Ownership											
30	Depreciation			55,288	55,288		55,288	9,855	65,143			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes			38,158	38,158		38,158		38,158			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle:											35
36	Other (specify):*											36
37	TOTAL Ownership			93,446	93,446		93,446	9,855	103,301			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportator											38
39	Ancillary Service Centers		78,399	215,540	293,939		293,939		293,939			39
40	Barber and Beauty Shops	11,952	985		12,937		12,937		12,937			40
41	Coffee and Gift Shops											41
42	Provider Participation Fec			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	11,952	79,384	280,145	371,481		371,481		371,481			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,861,049	397,390	1,025,749	3,284,188		3,284,188	(8,334)	3,275,854			45

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

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 Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,855	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund:				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 Retainer:				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,709)	21		26
27	CNA Training for Non-Employees:				27
28	Yellow Page Advertising	(4,622)			28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,956)		\$	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 ³	\$		31
32	Donated Goods-Attach Schedule ³			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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (12,956)		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		12,937	40	41
42	Laboratory and Radiology	X		21,294	39-3	42
43	Prescription Drugs	X		72,369	39-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 106,600		47

BHF USE ONLY

48		49		50		51		52	
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Facility Name & ID Number **FOUNTAINVIEW**

0020628

Report Period Beginning: **07-01-2008** Ending: **06-30-2009**

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

FOUNTAINVIEW

0020628

Report Period Beginning:

07-01-2008

Ending:

06-30-2009

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	1
2	DON R. DEARMON	SECRETARY	EXEC BOARD	23.66		2		DIR FEES	3,000	2
3	BILLY L. JONES	TREASURER	EXEC BOARD	15.12		2		DIR FEES	3,000	3
4	BILLY L. JONES	BUS MANAGER				18		BUS MGR.	32,900	4
5	EVERETT KNIGHT	DIRECTOR	EXEC BOARD	6.00		2		DIR FEES	3,000	5
6	ROBERT G. MORGAN	VICE PRES	EXEC BOARD	6.76		2		DIR FEES	3,000	6
7	JAMES B CHILDRESS	DIRECTOR	EXEC BOARD	13.52		2		DIR FEES	3,000	7
8	MARK W. KNIGHT	DIRECTOR	EXEC BOARD	4.52		2		DIR FEES	3,000	8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 53,900	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number FOUNTAINVIEW

0020628 Report Period Beginning: 07-01-2008 Ending: 6-30-2009

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

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	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

Facility Name & ID Number

FOUNTAINVIEW

0020628

Report Period Beginning:

07-01-2008

Ending:

06-30-2009

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										
										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)				\$	\$			\$ NONE	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(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>36,736.00</u>	\$ <u>36,736.00</u>
2. <u>04-2-095-06</u>	<u>FACILITY LOCATION ADDL LOT</u>	\$ <u>98.00</u>	\$ <u>98.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>36,834.00</u></u>	\$ <u><u>36,834.00</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

07-01-2008 Ending:

06-30-2009

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).

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:

	1	2	3	4	
A. Land.	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	TOTALS	222,800		\$ 22,145	3

Facility Name & 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	234,732	6
7		1993	1993	159,083	3,182	50	3,182		51,177	7
8		1998	1998	17,723	354	50	354		3,776	8
Improvement Type**										
9	ROOF		1982	20,564		10			20,567	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		3,305	12
13	OUTSIDE LIGHTS		1991	1,345		10			1,345	13
14	ROOF		1991	13,600		20	680	680	12,070	14
15	KITCHEN LIGHTS		1992	1,208		20	60	60	1,035	15
16	HAC UNITS		1992	26,114		15			26,114	16
17	ROOF		1992	9,000	450	20	450		7,500	17
18	HAC UNITS		1993	7,578		15			7,578	18
19	FENCE		1993	8,581	429	20	429		6,828	19
20	HAC UNITS		1993	2,023	21	15	21		2,023	20
21	HAC UNITS		1994	2,777		15			2,777	21
22	HAC UNITS		1994	2,124	124	15	124		2,124	22
23	HAC UNITS		1995	5,723	382	15	382		2,475	23
24	HAC UNITS		1996	4,050	270	15	270		3,645	24
25	REMODELING		1997	20,514	1,026	20	1,026		8,607	25
26	ROOF		1997	35,935		7			35,935	26
27	AC UNIT		1997	3,375	225	15	225		2,513	27
28	PARKING LOT & DRAINAGE		1998	44,413	888	50	888		9,472	28
29	DUMPSTER		1998	1,931	97	20	97		1,033	29
30	ROOF		1998	3,800		7			3,800	30
31	FIRE ALARM SYSTEM		1999	48,588	2,429	20	2,429		23,278	31
32	KITCHEN REMODELING		2000	7,307	365	20	365		3,315	32
33	METAL CANOPY		2000	3,508	175	20	175		1,633	33
34	ROOM NUMBERS & NAME PLATES		2000	1,472	73	20	73		681	34
35	LANDSCAPING		2000	1,411	71	20	71		651	35
36	FIRE SHUTTERS & BASEBOARDS		2001	6,991	699	10	699		5,709	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.

Facility Name & 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	
	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	\$	\$ 1,107	37
38	EMERGENCY POWER SUPPLY	2001	54,674	2,734	20	2,734		21,644	38
39	WINDOWS	2001	11,446	572	20	572		4,386	39
40	CABINETS	2002	3,174	159	20	159		1,153	40
41	HAC UNITS	2002	4,030	269	15	269		2,017	41
42	WATER HEATER	2003	3,470	174	20	174		1,131	42
43	ROOF	2004	34,230	1,712	20	1,712		9,986	43
44	WINDOWS	2004	4,308	215	20	215		1,147	44
45	AC UNIT	2004	638	64	10	64		378	45
46	AC UNIT	2004	3,000	200	15	200		1,033	46
47	BATHROOM RAILS	2004	344	17	20	17		86	47
48	COURT YARD	2005	33,997	1,700	20	1,700		8,217	48
49	RATHROOM REMODELING	2005	19,729	986	20	986		4,684	49
50	ROOF	2005	12,600	1,260	10	1,260		6,300	50
51	AC UNIT	2005	1,079	72	15	72		312	51
52	ELECTRICAL IMPROVEMENTS	2006	11,050	737	15	737		2,825	52
53	DOOR	2006	1,750	117	15	117		409	53
54	HAC UNITS	2006	5,075	338	15	338		1,211	54
55	HAC UNITS	2008	6,426	321	15	321		321	55
56	FLOOR TILING	1985	4,671		15			4,671	56
57	DOORS & SPRINKLERS	1988	4,116	84	20	84		4,116	57
58	SINK	1990	852		7			852	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,829,433	\$ 23,307		\$ 33,162	\$ 9,855	\$ 1,432,637	70

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

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	\$ 412,945	\$ 27,557	\$ 27,557	\$		\$ 231,795	71
72	Current Year Purchases	23,229	528	528			528	72
73	Fully Depreciated Assets	131,335					131,335	73
74								74
75	TOTALS	\$ 567,509	\$ 28,085	\$ 28,085	\$		\$ 363,658	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	98 FORD VAN	1999	\$ 26,198	\$ 2,620	\$ 2,620	\$	10	\$ 24,879	76
77	TRANSPORT RESIDENTS	2000 FORD VAN	2009	8,000	1,067	1,067		5	1,067	77
78	TRANSPORT RESIDENTS	95 CHEVY VAN	1998	12,775	209	209		10	12,775	78
79										79
80	TOTALS			\$ 46,973	\$ 3,896	\$ 3,896	\$		\$ 38,721	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)	\$ 2,466,060	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,288	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,143	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,855	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,835,016	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

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: _____*

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

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)	
TOTAL TRAINED	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$	5,253	\$ 82,336					5,253	\$ 82,336				1
2	Licensed Speech and Language Development Therapist	39-3	hrs		248	14,767					248	14,767				2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-3	hrs		1,677	97,143			1,100		1,677	98,243				4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>lab & xray</u>	39-3				21,294						21,294				12
13	Other (specify): <u>drugs & med supp</u>	39-2							77,299			77,299				13
14	TOTAL			\$	7,178	\$ 215,540			\$ 78,399		7,178	\$ 293,939				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

0020628

Report Period Beginning: 07-01-2008

Ending: 06-30-2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06-30-2009

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 776,475	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,219)	767,754		3
4	Supply Inventory (priced at COST)	11,609		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,560		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,586,398	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,145		13
14	Buildings, at Historical Cost	1,829,432		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	614,482		16
17	Accumulated Depreciation (book methods)	(1,888,438)		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)	\$ 577,621	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,164,019	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 164,042	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,646		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,388		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,037		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 338,113	\$	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)	\$ 338,113	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,825,906	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,164,019	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,720,691	1
2	Restatements (describe)		2
3	PRIOR PERIOD MEDICARE ADJUSTMENT	(166,201)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,554,490	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	663,896	7
8	Aquisitions of Pooled Companie:		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owner:	(392,480)	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 271,416	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)	\$ 1,825,906	24 *

* This must agree with page 17, line 47

Facility Name & ID Number FOUNTAINVIEW

0020628

Report Period Beginning: 07-01-2008

Ending: 06-30-2009

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,672,220	1
2	Discounts and Allowances for all Levels	268,212	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,940,432	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	2,063	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)	\$ 2,063	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,469	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	120	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 120	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,948,084	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	748,472	31
32	Health Care	1,453,800	32
33	General Administration	616,989	33
B. Capital Expense			
34	Ownership	93,446	34
C. Ancillary Expense			
35	Special Cost Centers	306,876	35
36	Provider Participation Fee	64,605	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,284,188	40
41	Income before Income Taxes (line 30 minus line 40)**	663,896	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 663,896	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:

07-01-2008

Ending:

06-30-2009

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	\$ 74,764	\$ 35.94	1
2	Assistant Director of Nursing	1,960	2,080	42,597	20.48	2
3	Registered Nurses	7,360	7,731	151,153	19.55	3
4	Licensed Practical Nurses	25,435	26,415	405,364	15.35	4
5	CNAs & Orderlies	62,192	64,914	569,793	8.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,921	1,998	19,032	9.53	9
10	Activity Assistants	3,572	3,871	41,770	10.79	10
11	Social Service Workers	3,729	3,857	39,616	10.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,970	2,032	19,352	9.52	14
15	Cook Helpers/Assistants	14,243	14,870	115,068	7.74	15
16	Dishwashers					16
17	Maintenance Workers	2,121	2,261	34,547	15.28	17
18	Housekeepers	13,291	14,538	123,604	8.50	18
19	Laundry	6,263	6,551	54,823	8.37	19
20	Administrator	1,960	2,080	65,049	31.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,920	4,160	66,529	15.99	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	2,728	2,913	26,036	8.94	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTY SHOP	1,120	1,272	11,952	9.40	33
34	TOTAL (lines 1 - 33)	155,745	163,623	\$ 1,861,049 *	\$ 11.37	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	71	\$ 10,497	1-3	35
36	Medical Director	12	750	9-3	36
37	Medical Records Consultant	30	1,538	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,190	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	71	4,875	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	196	\$ 18,850		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

Facility Name & ID Number FOUNTAINVIEW

0020628

Report Period Beginning: 07-01-2008 Ending: 06-30-2009

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 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? 10 YR.
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. : 20,409 Line 10
- (7) Have all costs reported on this form been determined using accounting procedure 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 X
- (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. \$ 64,605
This amount is to be recorded on line 42 of Schedule V _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? NO If YES, attach an explanation of the allocation _____
- (13) Have costs for all supplies and services which are of the type that can be billed 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 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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees _____