

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: _____</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) 273-4800</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>07/01/2013</u> to <u>06/30/2014</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Rhonda Travelstead</u> (Title) <u>Administrator</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>Reimbursement Director</u> (Firm Name & Address) <u>CliftonLarsonAllen</u> <u>600 Washington Avenue, Suite 1800</u> (Telephone) <u>(314)925-4300</u> Fax # <u>(314)925-4350</u> </td> </tr> </table> <p align="right"> 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) _____ (Type or Print Name) <u>Rhonda Travelstead</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>Reimbursement Director</u> (Firm Name & Address) <u>CliftonLarsonAllen</u> <u>600 Washington Avenue, Suite 1800</u> (Telephone) <u>(314)925-4300</u> Fax # <u>(314)925-4350</u>
<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 _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Rhonda Travelstead</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>Reimbursement Director</u> (Firm Name & Address) <u>CliftonLarsonAllen</u> <u>600 Washington Avenue, Suite 1800</u> (Telephone) <u>(314)925-4300</u> Fax # <u>(314)925-4350</u>							

Facility Name & ID Number Fountainview

0020628 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	38	Skilled (SNF)	38	13,870	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,555	2,555	8
9	SNF/PED					9
10	ICF	19,061	13,569		32,630	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,061	13,569	2,555	35,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.84%

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 2,555

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 06/30/2014

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

Facility Name & ID Number

Fountainview

0020628

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	148,660	11,373	8,895	168,928		168,928		168,928		1
2	Food Purchase		193,649		193,649		193,649	(721)	192,928		2
3	Housekeeping	117,086	15,863		132,949		132,949		132,949		3
4	Laundry	55,806	10,099		65,905		65,905		65,905		4
5	Heat and Other Utilities			85,412	85,412		85,412		85,412		5
6	Maintenance	50,423		133,574	183,997		183,997		183,997		6
7	Other (specify):*										7
8	TOTAL General Services	371,975	230,984	227,881	830,840		830,840	(721)	830,119		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,307,889	50,888	2,836	1,361,613		1,361,613		1,361,613		10
10a	Therapy	40,653		1,813	42,466		42,466		42,466		10a
11	Activities	55,423	3,269		58,692		58,692		58,692		11
12	Social Services	43,672		4,731	48,403		48,403		48,403		12
13	CNA Training										13
14	Program Transportation			4,515	4,515		4,515		4,515		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,447,637	54,157	13,895	1,515,689		1,515,689		1,515,689		16
	C. General Administration										
17	Administrative	122,640			122,640		122,640		122,640		17
18	Directors Fees			20,850	20,850		20,850		20,850		18
19	Professional Services			53,757	53,757		53,757		53,757		19
20	Dues, Fees, Subscriptions & Promotions			11,144	11,144		11,144	(1,217)	9,927		20
21	Clerical & General Office Expenses	36,680	10,943	52,868	100,491		100,491	(42,654)	57,837		21
22	Employee Benefits & Payroll Taxes			282,059	282,059		282,059		282,059		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,625	8,625		8,625		8,625		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			55,838	55,838		55,838	(944)	54,894		26
27	Other (specify):*										27
28	TOTAL General Administration	159,320	10,943	485,141	655,404		655,404	(44,815)	610,589		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,978,932	296,084	726,917	3,001,933		3,001,933	(45,536)	2,956,397		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: 07/01/2013 Ending: 06/30/2014

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			100,740	100,740		100,740	(1,053)	99,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,158	1,158		1,158	(1,158)				32
33	Real Estate Taxes			38,842	38,842		38,842	(1,672)	37,170			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Other Capital											36
37	TOTAL Ownership			140,740	140,740		140,740	(3,883)	136,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,952	264,772	364,724		364,724		364,724			39
40	Barber and Beauty Shops		1,407		1,407		1,407		1,407			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			272,670	272,670		272,670		272,670			42
43	Other (specify):* Chaplin	3,325			3,325		3,325		3,325			43
44	TOTAL Special Cost Centers	3,325	101,359	537,442	642,126		642,126		642,126			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,982,257	397,443	1,405,099	3,784,799		3,784,799	(49,419)	3,735,380			45

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

Facility Name & ID Number Fountainview

0020628

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

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				9
10	Interest and Other Investment Income	(1,158)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(721)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(870)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,759)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,025)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,217)	20		28
29	Other-Attach Schedule See PG 5A	(3,669)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,419)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (49,419)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Fountainview

ID# 0020628

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Real estate Tax on Rental	\$ (1,672)	33	1
2	Rental Depreciation	(1,053)	30	2
3	Rental Insurance	(944)	26	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(3,669)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fountainview# 0020628

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(721)	0	0	0	0	0	0	0	0	0	0	(721)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(721)	0	(721)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,217)	0	0	0	0	0	0	0	0	0	0	(1,217)	20
21	Clerical & General Office Expenses	(42,654)	0	0	0	0	0	0	0	0	0	0	(42,654)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(944)	0	0	0	0	0	0	0	0	0	0	(944)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(44,815)	0	(44,815)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,536)	0	(45,536)	29									

STATE OF ILLINOIS

Facility Name & ID Number Fountainview# 0020628

Report Period Beginning:

07/01/2013 Ending:

Summary B

06/30/2014

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(1,053)	0	0	0	0	0	0	0	0	0	0	(1,053)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,158)	0	0	0	0	0	0	0	0	0	0	(1,158)	32
33	Real Estate Taxes	(1,672)	0	0	0	0	0	0	0	0	0	0	(1,672)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,883)	0	0	0	0	0	0	0	0	0	0	(3,883)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(49,419)	0	0	0	0	0	0	0	0	0	0	(49,419)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert Morgan	7.57	Pope County Care Center	Golconda			
Alfert G. Bledig	30.81					
Don R. Dearmon	26.49					
Billy L. Jones	19.07					
Everett Knight	8.86					
Mark W. Knigh	7.2					

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: 07/01/2013 Ending: 06/30/2014

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	Alfret G. Bledig	President	Exec Board	30.81	None	2		Dir Fees	\$ 4,200	18-3	1
2	Don R. Dearmon	Director	Exec Board	26.49	None	2		Dir Fees	600	18-3	2
3	Billy L. Jones	Sec/Treasurer	Exec Board	19.07	None	2		Dir Fees	4,200	18-3	3
4	Billy L. Jones	Business Manager	Manage Facility	19.07	None	18		Bus. Mgr	34,900	19-3	4
5	Everett Knight	Director	Exec Board	8.86	None	2		Dir Fees	4,200	18-3	5
6	Robert Morgan	Director	Exec Board	7.57	None	2		Dir Fees	4,200	18-3	6
7	Mark W. Knight	Vice President	Exec Board	7.20	None	2		Dir Fees	3,450	18-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 55,750		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: 07/01/2013 Ending: 6/30/2014

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

Facility Name & ID Number

Fountainview

0020628

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	Name of Lender	2		3	4	5	6		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	James B. Childers		X	Working Capital	None	01/01/11	200,000	39,724	01/01/16	0.0150	1,158						
7																	
8																	
9	TOTAL Facility Related						\$ 200,000	\$ 39,724			\$ 1,158						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 200,000	\$ 39,724			\$ 1,158						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	60,598		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.)		\$	38,837		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(21,761)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,603		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	38,842		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>37,472</u>	8	FOR BHF USE ONLY	
	2010	<u>37,477</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>39,087</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>38,837</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>37,250</u>	12	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.

2013 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-1-159-04</u>	<u>Facility 7.89 Acres</u>	\$ <u>35,484.20</u>	\$ <u>35,484.20</u>
2. <u>04-2-095-06</u>	<u>Facility Additional Lot</u>	\$ <u>94.02</u>	\$ <u>94.02</u>
3. <u>04-1-137-14</u>	<u>Rental House</u>	\$ <u>1,671.84</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>37,250.06</u></u>	\$ <u><u>35,578.22</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

07/01/2013 Ending:

06/30/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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	Facility	205,512	1976	\$ 20,287	1
2	Facility	5,000	2006	646	2
3	TOTALS	210,512		\$ 20,933	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	99	1976	1976	\$ 844,244	\$		\$	\$	\$ 844,244	4
5	12	1983	1983	273,457					273,457	5
6		1993	1993	159,083	3,182	50	3,182		67,085	6
7		1998	1998	17,723	354	50	354		5,547	7
8										8
	Improvement Type**									
9	1982 Fixed Assets		1982	20,565		VAR				9
10	1985 Fixed Assets		1985	4,671		VAR				10
11	1988 Fixed Assets		1988	18,239		VAR				11
12	1990 Fixed Assets		1990	11,438		VAR				12
13	1991 Fixed Assets		1991	18,517		VAR				13
14	1992 Fixed Assets		1992	36,322		VAR				14
15	1993 Fixed Assets		1993	18,181		VAR				15
16	1994 Fixed Assets		1994	4,902		VAR				16
17	1995 Fixed Assets		1995	5,723		VAR				17
18	1996 Fixed Assets		1996	4,050		VAR				18
19	1997 Fixed Assets		1997	59,824		VAR				19
20	1998 Fixed Assets		1998	50,144		VAR				20
21	1999 Fixed Assets		1999	48,588		VAR				21
22	2000 Fixed Assets		2000	13,697		VAR				22
23	2001 Fixed Assets		2001	75,165		VAR				23
24	2002 Fixed Assets		2002	7,204		VAR				24
25	2003 Fixed Assets		2003	3,470		VAR				25
26	2004 Fixed Assets		2004	42,520		VAR				26
27	2005 Fixed Assets		2005	67,405		VAR				27
28	2006 Fixed Assets		2006	17,875		VAR				28
29	2008 Fixed Assets		2008	6,426		VAR				29
30	Sun room		2012	131,606		40				30
31	AC Unit		2012	5,940		15				31
32	A/C Unit		2012	5,940		15				32
33	Ventilation System		2012	373,025		15				33
34	Sprinkler System		2012	107,256		10				34
35	Landscaping		2013	8,573		15				35
36	Financial Statement Depreciation				57,676		57,676		471,998	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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 389,257	\$ 29,944	\$ 29,944	\$	VAR	\$ 262,800	71
72	Current Year Purchases	26,641	2,195	2,195		VAR	2,195	72
73	Fully Depreciated Assets	267,503				VAR	267,503	73
74								74
75	TOTALS	\$ 683,401	\$ 32,139	\$ 32,139	\$		\$ 532,498	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	98 Ford Van	1999	\$ 26,198	\$	\$	\$	10	\$ 26,198	76
77	Transport Residents	2000 Ford Van	2009	8,002	535	535		5	8,002	77
78	Transport Residents	2008 Ford Van	2010	34,803	5,801	5,801		6	26,588	78
79										79
80	TOTALS			\$ 69,003	\$ 6,336	\$ 6,336	\$		\$ 60,788	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,235,110	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,687	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,687	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,255,617	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental House	\$ 28,954	\$ 1,053	\$ 3,510	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 28,954	\$ 1,053	\$ 3,510	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: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

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.	<u>/2015</u>	\$ _____
13.	<u>/2016</u>	\$ _____
14.	<u>/2017</u>	\$ _____

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: \$ N/A Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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><u>Fountainview only hires trained CNAs.</u></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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$	1,797	\$ 109,243	\$	1,797	\$ 109,243	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs		158	9,964		158	9,964	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs		1,860	112,502	133	1,860	112,635	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Lab & X-Ray</u>	39-3				33,063			33,063	12	
13	Other (specify): <u>Drugs & Med Supply</u>	39-2					99,819		99,819	13	
14	TOTAL			\$	3,815	\$ 264,772	\$ 99,952	3,815	\$ 364,724	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: 07/01/2013Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,367,322	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	844,607		3
4	Supply Inventory (priced at)	13,807		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,057		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,258,793	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,933		13
14	Buildings, at Historical Cost	2,497,078		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	752,402		16
17	Accumulated Depreciation (book methods)	(2,259,127)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,011,286	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,270,079	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,026	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,421		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,365		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,603		32
33	Accrued Interest Payable	384		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)	\$ 364,799	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	39,724		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)	\$ 39,724	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 404,523	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,865,556	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,270,079	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,569,907	1
2	Restatements (describe):		2
3	Prior Year Medicare Adjustment		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,569,907	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	790,649	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	(495,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 295,649	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,865,556	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fountainview

0020628

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,879,397	1
2	Discounts and Allowances for all Levels	(42,797)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,836,600	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	513,605	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 513,605	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,138	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,563	19
20	Radiology and X-Ray	5,501	20
21	Other Medical Services	9,750	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 128,952	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,260	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,260	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	2,162	28
28a	Miscellaneous	74,869	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 77,031	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,575,448	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	830,840	31
32	Health Care	1,515,689	32
33	General Administration	655,404	33
B. Capital Expense			
34	Ownership	140,740	34
C. Ancillary Expense			
35	Special Cost Centers	366,131	35
36	Provider Participation Fee	272,670	36
D. Other Expenses (specify):			
37	<u>Chaplin</u>	3,325	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,784,799	40
41	Income before Income Taxes (line 30 minus line 40)**	790,649	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 790,649	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,872,045	44
45	Private Pay - Net Inpatient Revenue	1,524,068	45
46	Medicare - Net Inpatient Revenue	440,487	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,836,600	49

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

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

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

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

Facility Name & ID Number Fountainview

0020628

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	2,054	2,080	\$ 66,148	\$ 31.80	1
2	Assistant Director of Nursing	2,054	2,080	48,462	23.30	2
3	Registered Nurses	6,625	6,325	153,678	24.30	3
4	Licensed Practical Nurses	25,170	23,883	424,776	17.79	4
5	CNAs & Orderlies	61,397	59,094	589,605	9.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,928	3,574	40,653	11.37	8
9	Activity Director	1,856	1,801	17,662	9.81	9
10	Activity Assistants	3,879	3,632	37,761	10.40	10
11	Social Service Workers	3,714	3,639	43,672	12.00	11
12	Dietician					12
13	Food Service Supervisor	1,999	2,080	28,347	13.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,583	13,191	120,313	9.12	15
16	Dishwashers					16
17	Maintenance Workers	1,949	1,903	50,423	26.50	17
18	Housekeepers	12,624	11,878	118,806	10.00	18
19	Laundry	5,796	5,343	54,086	10.12	19
20	Administrator	1,839	2,080	60,567	29.12	20
21	Assistant Administrator	1,849	2,080	62,073	29.84	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,009	1,910	36,680	19.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	2,112	2,073	25,220	12.17	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Chaplin</u>	303	344	3,325	9.67	33
34	TOTAL (lines 1 - 33)	154,740	148,990	\$ 1,982,257 *	\$ 13.30	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	143	\$ 8,895	-13	35
36	Medical Director				36
37	Medical Records Consultant	32	1,636	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	10-3	39
40	Physical Therapy Consultant	23	1,813	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	72	4,731	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	\$ 18,275		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function				Description	Amount	Description	Amount			
Rhonda Travelstead	Administrator			Workers' Compensation Insurance	\$ 71,343	IDPH License Fee	\$ 4,330				
Lori Pritchard	Asst. Administrator			Unemployment Compensation Insurance	16,313	Advertising: Employee Recruitment	4,274				
				FICA Taxes	148,174	Health Care Worker Background Check (Indicate # of checks performed)					
				Employee Health Insurance	18,646	Patient Background Checks	96	962			
				Employee Meals		Public Relations		1,217			
				Illinois Municipal Retirement Fund (IMRF)*		Annual Report		361			
				Retirement	13,145						
				Uniform Allowance	3,604						
				Life Insurance	1,159						
				Drug Testing	796						
				Employee Incentives	8,879						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 122,640	TOTAL (agree to Schedule V, line 22, col.8)			\$ 282,059	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,927
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description	Line #	Amount	Description	Amount			
			\$			\$	Out-of-State Travel	\$			
							In-State Travel				
							Seminar Expense				
							See Attached Schedule	8,625			
							Entertainment Expense				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				(agree to Sch. V, line 24, col. 8)				
							TOTAL	\$ 8,625			
C. Professional Services											
Vendor/Payee	Type	Amount									
James Henson	Accounting	\$ 8,830									
Lisa Berry	Corp Minutes	540									
Jamestown Management	Accounting	6,210									
Brown & Roberts	Engineering Fees	2,627									
Billy L Jones	Management	34,900									
MargelPedicord	Medicaid Cons.	650									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 53,757	TOTAL			\$				

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Fountainview

0020628

Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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. N/A
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,375 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 272,670
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ 100
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.