



Facility Name & ID Number The Fountain's

# 0040642 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 11/30/01

	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>68</u>	Skilled (SNF)	<u>125</u>	<u>26,644</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>68</u>	TOTALS	<u>125</u>	<u>26,644</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>1,875</u>	<u>238</u>	<u>1,399</u>	<u>3,512</u>	8
9	SNF/PED					9
10	ICF	<u>16,866</u>	<u>4,515</u>		<u>21,381</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,741</u>	<u>4,753</u>	<u>1,399</u>	<u>24,893</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.43%

D. How many bed-hold days during this year were paid by Public Aid? 144 (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 01/09/95

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/09/95 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 1,399

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 12/31

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

STATE OF ILLINOIS

Facility Name & ID Number      The Fountain's      #      0040642      Report Period Beginning:      01/01/01      Ending:      12/31/01

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	87,943	10,801	3,526	102,270		102,270		102,270		1
2	Food Purchase		86,415		86,415	(4,000)	82,415	(200)	82,215		2
3	Housekeeping	100,851	13,955		114,806		114,806		114,806		3
4	Laundry		12,687		12,687		12,687		12,687		4
5	Heat and Other Utilities			53,795	53,795		53,795	1,119	54,914		5
6	Maintenance	49,378		60,123	109,501		109,501	1,384	110,885		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	238,172	123,858	117,444	479,474	(4,000)	475,474	2,303	477,777		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	541,727	46,340	2,975	591,042		591,042		591,042		10
10a	Therapy										10a
11	Activities	27,127	1,420		28,547		28,547		28,547		11
12	Social Services	23,144		443	23,587		23,587		23,587		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	591,998	47,760	3,418	643,176		643,176		643,176		16
	<b>C. General Administration</b>										
17	Administrative	11,590			11,590		11,590	21,521	33,111		17
18	Directors Fees										18
19	Professional Services			150,943	150,943		150,943	(135,925)	15,018		19
20	Dues, Fees, Subscriptions & Promotions			15,671	15,671	10,415	26,086	(9,451)	16,635		20
21	Clerical & General Office Expenses	17,075	26,398	25,107	68,580		68,580	36,705	105,285		21
22	Employee Benefits & Payroll Taxes			144,018	144,018	(6,415)	137,603	10,996	148,599		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,377	2,377		2,377		2,377		24
25	Other Admin. Staff Transportation			3,034	3,034		3,034	3,574	6,608		25
26	Insurance-Prop.Liab.Malpractice			54,051	54,051		54,051	283	54,334		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	28,665	26,398	395,201	450,264	4,000	454,264	(72,297)	381,967		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	858,835	198,016	516,063	1,572,914		1,572,914	(69,994)	1,502,920		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 The Fountain's

#0040642

Report Period Beginning:

01/01/01

Ending:

12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,976	9,976		9,976	59,007	68,983			30
31	Amortization of Pre-Op. & Org.							1,555	1,555			31
32	Interest			77,811	77,811		77,811	46,171	123,982			32
33	Real Estate Taxes							22,953	22,953			33
34	Rent-Facility & Grounds			201,000	201,000		201,000	(196,261)	4,739			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			288,787	288,787		288,787	(66,575)	222,212			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,230	37,230		37,230		37,230			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			37,230	37,230		37,230		37,230			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	858,835	198,016	842,080	1,898,931		1,898,931	(136,569)	1,762,362			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 The Fountain's

# 0040642

Report Period Beginning: 01/01/01

Ending: 12/31/01

**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,359	30		9
10	Interest and Other Investment Income	(1,712)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(200)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,451)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule ABS Management	(136,922)	19		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (146,926)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	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)	(70,783)		34
35	Other- Attach Schedule Allocate Indirect Cost	81,140		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 10,357		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (136,569)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

The Fountain's

ID# 0040642

Report Period Beginning: 01/01/01

Ending: 12/31/01

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number The Fountain's

# 0040642

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(200)	0	0	0	0	0	0	0	0	0	0	(200)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(200)</b>	<b>0</b>	<b>(200)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,451)	0	0	0	0	0	0	0	0	0	0	(9,451)	20
21	Clerical & General Office Expenses	0	998	0	0	0	0	0	0	0	0	0	998	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(9,451)</b>	<b>998</b>	<b>0</b>	<b>(8,453)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(9,651)</b>	<b>998</b>	<b>0</b>	<b>(8,653)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Fountain's# 0040642 Report Period Beginning:

01/01/01 Ending:

12/31/01

## 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)
	<b>D. Ownership</b>												
30	Depreciation	1,359	57,648	0	0	0	0	0	0	0	0	0	59,007 30
31	Amortization of Pre-Op. & Org.	0	1,555	0	0	0	0	0	0	0	0	0	1,555 31
32	Interest	(1,712)	47,063	0	0	0	0	0	0	0	0	0	45,351 32
33	Real Estate Taxes	0	22,953	0	0	0	0	0	0	0	0	0	22,953 33
34	Rent-Facility & Grounds	0	(201,000)	0	0	0	0	0	0	0	0	0	(201,000) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(353)</b>	<b>(71,781)</b>	<b>0</b>	<b>(72,134) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(10,004)</b>	<b>(70,783)</b>	<b>0</b>	<b>(80,787) 45</b>								

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
See Schedule Attached		See Schedule Attached		Fountain, LLC.	Marion	Bldg. Rental
				ABS Management	Chicago	Management

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 201,000	The Willow of the Fountain, LLC.	100.00%	\$	\$ (201,000)
2	V	33 Real Estate Tax		The Willow of the Fountain, LLC.		22,953	22,953
3	V	32 Interest		The Willow of the Fountain, LLC.		47,063	47,063
4	V	30 Depreciation		The Willow of the Fountain, LLC.		57,648	57,648
5	V	31 Amortization		The Willow of the Fountain, LLC.		1,555	1,555
6	V	21 Office		The Willow of the Fountain, LLC.		998	998
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 201,000			\$ 130,217	\$ * (70,783)

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

Facility Name & ID Number      The Fountain's      #      0040642      Report Period Beginning:      01/01/01      Ending:      12/31/01

## 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	Sam Brandman		Administrative	5.00	41,711	2.17	4.00	ABS Salary	\$ 4,289	17-7	1
2	David Abell		Administrative	9.50	63,474	4.75	9.50	ABS Salary	6,526	17-7	2
3	Tamar Abell		Administrative	9.50	36,271	3.5	7.00	ABS Salary	3,729	17-7	3
4	Joseph Brandman		Administrative	19.00	67,854	4	8.00	ABS Salary	6,977	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,521		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 The Fountain's # 0040642 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 ABS Management  
 Street Address 2711 W. Howard  
 City / State / Zip Code Chicago, IL 60645  
 Phone Number ( 773-338-4400  
 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	17	Sam Brandman	783		\$ 46,000	\$ 46,000	73	\$ 4,289	1
2	17	David Abell	783		70,000	70,000	73	6,526	2
3	17	Tamar Abell	783		40,000	40,000	73	3,729	3
4	17	Joseph Brandman	783		74,831	74,831	73	6,977	4
5	21	Clerical	783		255,967	255,967	73	23,864	5
6	6	Repairs & Maintenance	783		14,844		73	1,384	6
7	34	Rent	783		50,826		73	4,739	7
8	22	Health & Welfare	783		73,457		73	6,848	8
9	26	Insurance	783		3,036		73	283	9
10	21	Office	783		127,030		73	11,843	10
11	19	Professional Fees	783		10,698		73	997	11
12	22	Payroll Taxes	783		44,494		73	4,148	12
13	5	Utilities	783		12,002		73	1,119	13
14	25	Auto & Travel	783		38,330		73	3,574	14
15	32	Interest	783		8,799		73	820	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 870,314	\$ 486,798		\$ 81,140	25

Facility Name & ID Number The Fountain's # 0040642 Report Period Beginning: 01/01/01 Ending: 12/31/01

## 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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Bank Leumi		X	Mortgage	\$5,500.00	01/10/95	\$ 1,000,000	\$ 549,000		9.5000	\$ 47,063	1								
2	Bank Leumi		X	Construction		04/01/01	1,000,000	2,559,396		7.0000	65,516	2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6	Bank Leumi		X	Working Capital			200,000	180,000		7.0000	12,295	6								
7	Bank Leumi-From ABS		X	Working Capital							820	7								
8												8								
9	TOTAL Facility Related				\$5,500.00		\$ 2,200,000	\$ 3,288,396			\$ 125,694	9								
	<b>B. Non-Facility Related*</b>																			
10	Interest Income										(1,712)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (1,712)	14								
15	TOTALS (line 9+line14)						\$ 2,200,000	\$ 3,288,396			\$ 123,982	15								

\* 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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The Fountain's COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0040642

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: ( )

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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>07-17-151-001</u>	<u></u>	\$ <u>22,210.46</u>	\$ <u>22,210.46</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>		\$ <u>22,210.46</u>	\$ <u>22,210.46</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number The Fountain's# 0040642 Report Period Beginning:01/01/01 Ending:12/31/01**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 16,500 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: 23,329 2. Number of Years Over Which it is Being Amortized: 15  
3. Current Period Amortization: 1,555 4. Dates Incurred: 01/10/95Nature of Costs: Goodwill, Mortgage Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1995</u>	<u>\$ 65,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 65,000</b>	<b>3</b>

Facility Name & ID Number The Fountain's

# 0040642

Report Period Beginning:

01/01/01

Ending:

12/31/01

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	68	1995		\$ 856,000	\$ 21,949	39	\$ 21,949	\$	\$ 152,728	4
5	57		2001	2,607,323	9,336	39	5,571	(3,765)	5,571	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Roof	1995		6,500		39	167	167	1,169	9
10	Decorating	1995		8,100		39	208	208	1,456	10
11	Painting	1995		17,459		39	448	448	3,136	11
12	Roof Repair	1998		8,080	207	39	207		768	12
13	<b>Existing Building Construction:</b>									13
14	HSG Mechanical Control-Walk-in cooler/freezer	2001		27,300	58	39	58		58	14
15	LTC Interiors	2001		43,301	93	39	93		93	15
16	Roof Repair	2001		6,826	15	39	15		15	16
17	Burke Electric	2001		125,000	267	39	267		267	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

\*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)

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,705,889	\$ 31,925		\$ 28,983	\$ (2,942)	\$ 165,261		70

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

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	\$ 400,000	\$ 35,699	\$ 40,000	\$ 4,301	10	\$ 280,000	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 400,000	\$ 35,699	\$ 40,000	\$ 4,301		\$ 280,000	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,170,889	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,624	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,983	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,359	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 445,261	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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from ABS Management				4,739			5
6								6
7	<b>TOTAL</b>				\$ 4,739			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. \_\_\_\_\_/2002      \$ \_\_\_\_\_  
13. \_\_\_\_\_/2003      \$ \_\_\_\_\_  
14. \_\_\_\_\_/2004      \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

\* 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 aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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 AIDE _____</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 AIDE _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											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	Exceptional Care Program													12
13	Other (specify):													13
14	<b>TOTAL</b>			\$		\$		\$		\$			\$	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 nurse aides, who help with the above activities should not be listed on this schedule.**

Facility Name &amp; ID Number The Fountain's

# 0040642

Report Period Beginning: 01/01/01

Ending:

12/31/01

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ (87,360)	\$ (68,896)	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	519,732	519,732	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	101,048	101,048	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <b>Due from Others</b>	164,852	91,999	9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 698,272	\$ 643,883	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		65,000	13
14 Buildings, at Historical Cost		856,000	14
15 Leasehold Improvements, at Historical Cost	3,055,929	3,055,929	15
16 Equipment, at Historical Cost		400,000	16
17 Accumulated Depreciation (book methods)	(10,537)	(545,415)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		23,329	19
Accumulated Amortization -			
20 Organization & Pre-Operating Costs		(10,847)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,045,392	\$ 3,843,996	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,743,664	\$ 4,487,879	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 117,263	\$ 117,263	26
27 Officer's Accounts Payable	5,906	131,906	27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	180,000	180,000	29
30 Accrued Salaries Payable	79,481	79,481	30
31 Accrued Taxes Payable (excluding real estate taxes)	10,506	10,506	31
32 Accrued Real Estate Taxes(Sch.IX-B)		22,654	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <b>Accrued Management Fees</b>	104,529	104,529	36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 497,685	\$ 646,339	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	2,559,396	2,559,396	39
40 Mortgage Payable		549,000	40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,559,396	\$ 3,108,396	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,057,081	\$ 3,754,735	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ 686,583	\$ 733,144	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,743,664	\$ 4,487,879	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 412,078	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 412,078	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	314,505	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	(40,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 274,505	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 686,583	24 *

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

Facility Name & ID Number The Fountain's

# 0040642

Report Period Beginning: 01/01/01

Ending: 12/31/01

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,216,057	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,216,057	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,387	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,387	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,217,444	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	479,474	31
32	Health Care	643,176	32
33	General Administration	450,264	33
<b>B. Capital Expense</b>			
34	Ownership	288,787	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	37,230	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,898,931	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	318,513	41
42	<b>Income Taxes</b>	(4,008)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 314,505	43

\* 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 The Fountain's

# 0040642

Report Period Beginning: 01/01/01

Ending:

12/31/01

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	2,160	2,175	\$ 40,495	\$ 18.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,194	4,525	71,513	15.80	3
4	Licensed Practical Nurses	10,616	11,226	123,453	11.00	4
5	Nurse Aides & Orderlies	37,637	39,779	306,266	7.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,231	3,246	27,127	8.36	10
11	Social Service Workers	2,400	2,409	23,144	9.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,160	15,120	7.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,848	11,472	72,823	6.35	15
16	Dishwashers					16
17	Maintenance Workers	5,716	5,755	49,378	8.58	17
18	Housekeepers	14,184	14,863	100,851	6.79	18
19	Laundry					19
20	Administrator	632	632	11,590	18.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,516	2,612	17,075	6.54	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,214	100,854	\$ 858,835 *	\$ 8.52	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	84	\$ 3,526	1-3	35
36	Medical Director				36
37	Medical Records Consultant	6	304	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	2,672	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	8	443	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	182	\$ 6,945		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	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Barbara Davis	Administrator	0	\$ 11,590	Workers' Compensation Insurance	\$ 32,660	IDPH License Fee	\$ 200	
				Unemployment Compensation Insurance	16,217	Advertising: Employee Recruitment	10,415	
				FICA Taxes	65,741	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	29,981	Dues-ICLTC	3,644	
				Employee Meals	4,000	Dues-Marion Chamber of Commerce	1,050	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	9,451	
						Misc Subscriptions	1,326	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 11,590			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(9,451)	
Description			Amount			Yellow page advertising	( )	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,635	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 148,599			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
Mendel S Schneider	Accounting		\$ 8,300				Out-of-State Travel	\$
Richard Peelo	Accounting		3,500					
Frost, Ruttenberg & Rothblatt	Accounting		666				In-State Travel	
Personnel Planners	U.C. Tax Consultant		945					
ABS Management	Home Office		136,922				Seminar Expense	
Meyer Magence	Legal		260				Professional Therapy	2,000
Sachnoff & Weaver	Legal		350				ICLTC	228
							Various	149
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 150,943	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 2,377

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number The Fountain's# 0040642Report Period Beginning: 01/01/01Ending: 12/31/01**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? Yes  
If YES, give association name and amount. ICLTC-3644
- (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? 39
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,230  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 4,000 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.