

Facility Name & ID Number Four Fountains Convalescent Center

0030304 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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	156	Skilled (SNF)	156	57,096	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	156	TOTALS	156	57,096	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				
		Public Aid Recipient	Private Pay	Other		Total
8	SNF	1,148	166	2,044	3,358	8
9	SNF/PED					9
10	ICF	27,124	16,535		43,659	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,272	16,701	2,044	47,017	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.35%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 11/04/1985

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/4/1985 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 17 and days of care provided 1,760

Medicare Intermediary AdminaStar 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.

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Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2004 Ending: 12/31/2004**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	A. General Services										
1	Dietary	254,455	19,880	2,769	277,104		277,104	277,104			1
2	Food Purchase		195,131		195,131		195,131	195,131			2
3	Housekeeping	154,922	25,390	6,996	187,308		187,308	187,308			3
4	Laundry	67,644	14,857		82,501		82,501	82,501			4
5	Heat and Other Utilities			114,101	114,101		114,101	114,101			5
6	Maintenance	63,329	20,380	21,073	104,782		104,782	104,782			6
7	Other (specify):*										7
8	TOTAL General Services	540,350	275,638	144,939	960,927		960,927	960,927			8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200	7,200			9
10	Nursing and Medical Records	1,860,983	77,015	313,344	2,251,342		2,251,342	2,251,342			10
10a	Therapy			134,186	134,186		134,186	134,186			10a
11	Activities	87,975	5,432		93,407		93,407	93,407			11
12	Social Services	82,655	115		82,770		82,770	82,770			12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,031,613	82,562	454,730	2,568,905		2,568,905	2,568,905			16
	C. General Administration										
17	Administrative	132,795		104,589	237,384		237,384	237,384			17
18	Directors Fees										18
19	Professional Services			40,354	40,354		40,354	40,354			19
20	Dues, Fees, Subscriptions & Promotions			22,457	22,457		22,457	(7,349)	15,108		20
21	Clerical & General Office Expenses	152,047	13,134	51,535	216,716		216,716	216,716			21
22	Employee Benefits & Payroll Taxes			490,634	490,634		490,634	490,634			22
23	Inservice Training & Education										23
24	Travel and Seminar			3,509	3,509		3,509	3,509			24
25	Other Admin. Staff Transportation			3,601	3,601		3,601	3,601			25
26	Insurance-Prop.Liab.Malpractice			242,818	242,818		242,818	242,818			26
27	Other (specify):* Contrib/sales tax			18,659	18,659		18,659	(18,659)			27
28	TOTAL General Administration	284,842	13,134	978,156	1,276,132		1,276,132	(26,008)	1,250,124		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,856,805	371,334	1,577,825	4,805,964		4,805,964	(26,008)	4,779,956		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.

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Facility Name & ID Number

Four Fountains Convalescent Center

#0030304

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	
	D. Ownership											
30	Depreciation			264,678	264,678		264,678		264,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			211,189	211,189		211,189		211,189			32
33	Real Estate Taxes			86,185	86,185		86,185		86,185			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,584	7,584		7,584		7,584			35
36	Other (specify):*											36
37	TOTAL Ownership			569,636	569,636		569,636		569,636			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,553	5,436	61,989		61,989		61,989			39
40	Barber and Beauty Shops	21,833	1,107	1,023	23,963		23,963		23,963			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,028	86,028		86,028		86,028			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	21,833	57,660	92,487	171,980		171,980		171,980			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,878,638	428,994	2,239,948	5,547,580		5,547,580	(26,008)	5,521,572			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 **Four Fountains Convalescent Center**

0030304

Report Period Beginning: **01/01/2004**

Ending: **12/31/2004**

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17,059)	27		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	(1,600)	27		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	(2,972)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,377)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,008)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (26,008)		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	TOTAL (C): (sum of lines 38-46)			\$		47

Four Fountains Convalescent Center

ID# 0030304

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	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	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	(7,349)	0	0	0	0	0	0	0	0	0	0	(7,349)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(18,659)	0	0	0	0	0	0	0	0	0	0	(18,659)	27
28	TOTAL General Administration	(26,008)	0	0	0	0	0	0	0	0	0	0	(26,008)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,008)	0	0	0	0	0	0	0	0	0	0	(26,008)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Four Fountains Convalescent Center**# **0030304**

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(26,008)	0	0	0	0	0	0	0	0	0	0	(26,008) 45

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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
Four Fountains Associates	100					

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name 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 Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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	Steven Brant	Manager	Administrative	2.30	A	30	50.00	Salary	\$ 45,426	17-1	1
2	Tim Crowley	Director/President	Administrative	0.00		8	20.00	Dir Fees	104,589	17-3	2
3											3
4											4
5											5
6			A- Columbia Conv Ctr		29,953						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 150,015		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 Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	Union Planters Bank		X	Mortgage	varies	3/1/05	\$ 5,100,000	\$ 4,881,639	4/1/2010	variable	\$ 200,957	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6	Southwest Bank		X	Work Cap	revolving	2/1/02	350,000	237,000	05/01/04	5.2500	10,232	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 5,450,000	\$ 5,118,639			\$ 211,189	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 5,450,000	\$ 5,118,639			\$ 211,189	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Four Fountains Convalescent Center**# **0030304** Report Period Beginning: **01/01/2004** Ending: **12/31/2004****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 2003 report.	\$			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.)	\$	86,185		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	86,185		3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			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.	\$	86,185		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	72,791	8	
		2000	71,019	9	
		2001	75,392	10	
		2002	78,488	11	
		2003	86,185	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2003	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Four Fountains Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0030304

CONTACT PERSON REGARDING THIS REPORT Steve Brant

TELEPHONE 618-277-7700 FAX #: 618-277-7363

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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>08-28.0-403-001</u>	<u>LOT/SEC-1 PT LYG S OF RICH CR</u>	\$ <u>268.56</u>	\$ <u>268.56</u>
2. <u>08-28.0-403-002</u>	<u>LOT/SEC-2 PT LYG S OF RICH CR</u>	\$ <u>82.78</u>	\$ <u>82.78</u>
3. <u>08-28.0-403-003</u>	<u>LOT/SEC-3 PT LYG S OF RICH CR</u>	\$ <u>41.12</u>	\$ <u>41.12</u>
4. <u>08-28.0-403-004</u>	<u>LOT/SEC-4 PT LYG S OF RICH CR</u>	\$ <u>41.12</u>	\$ <u>41.12</u>
5. <u>08-28.0-403-055</u>	<u>LOT/SEC 58 PT LTS 57 & 58</u>	\$ <u>79,147.18</u>	\$ <u>79,147.18</u>
6. <u>08-28.0-403-056</u>	<u>LOT/SEC 58 PT LTS 57 & 58(2701)</u>	\$ <u>6,275.54</u>	\$ <u>6,275.54</u>
7. <u>08-28.0-403-066</u>	<u>LOT/SEC 58 PT LT 58</u>	\$ <u>328.26</u>	\$ <u>328.26</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>86,184.56</u>	\$ <u>86,184.56</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Four Fountains Convalescent Center# 0030304 Report Period Beginning:01/01/2004 Ending:12/31/2004**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 51,562 B. General Construction Type: Exterior brick Frame steel Number of Stories _____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, nurse aide 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	218,250	1985	\$ 585,985	1
2					2
3	TOTALS	218,250		\$ 585,985	3

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

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	140	1985	1972	\$ 3,826,500	\$ 127,550	30	\$ 127,550	\$	\$ 2,357,225
5	16	1996	1996	1,641,547	51,410	var	51,410		596,155
6									
7									
8									
Improvement Type**									
9	Building Improvements	1986		23,852	795	30	795		14,706
10	Land Improvements	1991		3,947		15			
11	Building Improvements	1987		10,614	354	30	354		6,194
12	Building Improvements	1988		11,664	389	30	389		6,417
13	Building Improvements	1989		192,108	6,404	30	6,404		97,690
14	Parking Lot Repavement	1989		20,043		15			19,373
15	Building Improvements	1990		42,771	1,426	30	1,426		20,678
16	Building Improvements	1991		30,378	1,013	30	1,013		14,180
17	Land Improvements	1991		1,127	75	15	75		1,051
18	Building Improvements	1992		11,841	790	30	790		9,785
19	Carpeting	1992		318		7			315
20	Land Improvements	1992		3,777	252	15	252		3,134
21	Building Improvements	1993		1,253		7			1,253
22	Land Improvements	1993		2,581	173	15	173		2,024
23	Building Improvements	1993		12,614	841	15	841		9,747
24	Building Improvements	1994		6,876	459	15	459		5,012
25	Building Improvements & Land Improvements	1994		40,120	2,992	10	2,992		40,118
26	Building Improvements	1995		16,869	1,125	15	1,125		11,016
27	Building Improvements	1995		33,390	3,337	10	3,337		32,421
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

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	Hot Water Pipes	1997	\$ 1,303	\$ 130	10	\$ 130	\$	\$ 934	37
38	Storage Shed	1997	1,002	100	10	100		776	38
39	Laundry Water Tank	1997	2,050	205	10	205		1,640	39
40	Remodeling	1998	2,090	139	15	139		871	40
41	Replace Asphalt	1998	8,525	853	10	853		5,186	41
42	Therapy Kitchen	1999	7,500	500	15	500		2,958	42
43	Roof	1999	112,353	7,490	15	7,490		43,068	43
44	Shower	1999	1,910	127	15	127		732	44
45	Therapy Kitchen	1999	2,802	187	15	187		1,043	45
46	Water Heater	1999	9,806	654	15	654		3,596	46
47	Safe Stride Slip Resistant Floor	1999	480	32	15	32		163	47
48	Asphalt	2000	2,765	138	20	138		634	48
49	Sign Lettering	2000	900	45	20	45		203	49
50	Fire Suppresion System, remodeling	2000	24,431	1,842	15	1,842		7,822	50
51									51
52	New lighting and fixtures	2001	6,360	424	15	424		1,519	52
53	New drains hall 100	2001	4,843	323	15	323		1,291	53
54	Day room remodel	2001	5,671	378	15	378		1,292	54
55	Dining room remodel hall 500	2001	12,079	805	15	805		2,751	55
56	Ansul system hookup	2001	1,900	127	10	127		507	56
57	Wallpaper, plaster,door	2002	8,146	543	15	543		1,320	57
58	Flooring	2003	480	32	5	32		64	58
59	Boiler and circuits	2003	4,900	327	10	327		588	59
60	Signage	2003	1,075	72	15	72		96	60
61	Storage	2003	2,835	284	15	284		499	61
62	Sprinklers	2004	1,108	55	15	55		55	62
63	Hall improvements/Metal door	2004	4,210	180	15	180		180	63
64	Asphalt	2004	4,155	52	20	52		52	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,169,869	\$ 215,429		\$ 215,429	\$	\$ 3,328,334	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 625,019	\$ 46,677	\$ 46,677	\$		\$ 305,726	71
72	Current Year Purchases	28,186	2,571	2,571		3-10 yr	2,571	72
73	Fully Depreciated Assets	1,030,703					1,030,703	73
74	Rounding						1	74
75	TOTALS	\$ 1,683,908	\$ 49,248	\$ 49,248	\$		\$ 1,339,001	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)	\$ 8,439,762	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 264,677	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,677	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)	\$ 4,667,335	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

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> /2005 </u>	\$ <u> </u>
13.	<u> /2006 </u>	\$ <u> </u>
14.	<u> /2007 </u>	\$ <u> </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: \$ 7,584 Description: Office 5920, Dietary 1164 Medical 500
 (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.

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

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)	
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 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.

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 32,477	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	798,885		3
4 Supply Inventory (priced at cost)	35,615		4
5 Short-Term Investments			5
6 Prepaid Insurance	29,421		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 896,398	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	585,985		13
14 Buildings, at Historical Cost	6,106,772		14
15 Leasehold Improvements, at Historical Cost	1,417,602		15
16 Equipment, at Historical Cost	329,403		16
17 Accumulated Depreciation (book methods)	(4,667,335)		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): Capitalized loan costs(net)	72,199		23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,844,626	\$	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,741,024	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 180,764	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	142,892		30
31 Accrued Taxes Payable (excluding real estate taxes)	4,110		31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable	20,650		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Accrued Mgmt Fees</u>	331,588		36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 680,004	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	237,000		39
40 Mortgage Payable	4,881,639		40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,118,639	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,798,643	\$	46
47 TOTAL EQUITY (page 18, line 24)	\$ (1,057,619)	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,741,024	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (857,621)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (857,621)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(199,997)	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	()	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)	\$ (199,997)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,057,618)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,011,026	1
2	Discounts and Allowances for all Levels	(62,156)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,948,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	195,193	6
7	Oxygen	12,978	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 208,170	8
C. Other Operating Revenue			
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	33,575	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,960	17
18	Sale of Supplies to Non-Patients	42,716	18
19	Laboratory	15,173	19
20	Radiology and X-Ray	4,616	20
21	Other Medical Services		21
22	Laundry	805	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 189,845	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	100	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 100	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	598	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 598	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,347,583	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	960,927	31
32	Health Care	2,568,905	32
33	General Administration	1,276,132	33
B. Capital Expense			
34	Ownership	569,636	34
C. Ancillary Expense			
35	Special Cost Centers	85,952	35
36	Provider Participation Fee	86,028	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,547,580	40
41	Income before Income Taxes (line 30 minus line 40)**	(199,997)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (199,997)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

return on extension

*** 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 **Four Fountains Convalescent Center**

0030304

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,878	\$ 57,158	\$ 30.44	1
2	Assistant Director of Nursing	1,904	51,348	24.69	2
3	Registered Nurses	14,969	366,011	22.60	3
4	Licensed Practical Nurses	20,457	387,421	17.57	4
5	Nurse Aides & Orderlies	85,100	963,886	9.80	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	3,837	35,159	8.39	8
9	Activity Director				9
10	Activity Assistants	10,376	87,975	7.97	10
11	Social Service Workers	3,864	82,655	19.87	11
12	Dietician	1,944	39,041	18.77	12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	29,240	215,414	7.03	15
16	Dishwashers				16
17	Maintenance Workers	4,633	63,329	12.47	17
18	Housekeepers	19,442	154,922	7.22	18
19	Laundry	8,617	67,644	7.31	19
20	Administrator	1,944	87,369	42.00	20
21	Assistant Administrator				21
22	Other Administrative	1,054	45,426	38.24	22
23	Office Manager				23
24	Clerical	12,487	152,047	10.99	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>Beauty Shop</u>	1,911	21,833	10.90	33
34	TOTAL (lines 1 - 33)	223,657	\$ 2,878,638 *	\$ 11.63	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	\$	1-3	35
36	Medical Director	monthly 7,200	9-3	36
37	Medical Records Consultant	11 385	10-3	37
38	Nurse Consultant		10-3	38
39	Pharmacist Consultant	14 720	10-3	39
40	Physical Therapy Consultant	varies 45,353	10-3	40
41	Occupational Therapy Consultant	varies 14,500	10-3	41
42	Respiratory Therapy Consultant	g		42
43	Speech Therapy Consultant	varies 4,800	10-3	43
44	Activity Consultant			44
45	Social Service Consultant		12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	25 \$ 72,958		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	15 \$ 488		50
51	Licensed Practical Nurses	4,660 129,462	10-3	51
52	Nurse Aides	7,970	10-3	52
53	TOTAL (lines 50 - 52)	12,645 \$ 129,950		53

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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	
Hope McNitt	Administrator	0	\$ 87,369	Workers' Compensation Insurance	\$ 82,567	IDPH License Fee	\$ 2,560	
Steve Brant	Exec Admin	2.3	45,426	Unemployment Compensation Insurance	23,101	Advertising: Employee Recruitment	10,371	
				FICA Taxes	209,482	Health Care Worker Background Check	956	
				Employee Health Insurance	170,362	(Indicate # of checks performed <u>80</u>)		
				Employee Meals		Group Purchasing	120	
				Illinois Municipal Retirement Fund (IMRF)*		various publications	753	
				401K	2,298	CLIA Lab waiver	150	
				Other Misc	2,824	Antivirus	198	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 132,795	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other						Less: Public Relations Expense ()		
Description			Amount			Non-allowable advertising ()		
Tim Crowley			\$ 104,589			Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 104,589			TOTAL (agree to Sch. V, line 24, col. 8)		
C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Rubin Brown and Gornstein	Accounting/Audit	22,020				Out-of-State Travel	\$	
David Read CPA	Consulting/Accounting	2,650				In-State Travel		
Moore Renner & Simonin	Accounting	77		N/A		Seminar Expense	3,509	
Union Planters Bank	Legal	3,750				Entertainment Expense ()		
Greensfelder Hemke gale	Legal	485				(agree to Sch. V, line 24, col. 8)		
Hinshaw Culbertson	Legal	4,256				TOTAL	\$ 3,509	
Jennings Jacknewitz	Legal	3,854						
Wessel & Pautsch	Legal	120						
Van Ostrand & Elvidge	Legal	1,236						
Janis Lee	Accounting	1,906						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 40,354	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,582 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 86,028
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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Rubin Brown & Gornstein The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.