

		FOR BHF USE				

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0030304

Facility Name: Four Fountains Convalescent Center

Address: 101 South Belt West Belleville 62220
 Number City Zip Code

County: St. Clair

Telephone Number: 618-277-7700 **Fax #** 618-277-7363

HFS ID Number: 37-1182089001

Date of Initial License for Current Owners: 11/4/1985

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Tara Hamilton **Telephone Number:** 618-277-7700

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Tara Hamilton</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>David C. Read</u> <u>Consultant</u>	
	(Firm Name & Address) _____	
	(Telephone) <u>618-234-2273</u> Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Four Fountains Convalescent Center# 0030304 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>156</u>	Skilled (SNF)	<u>156</u>	<u>56,940</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>156</u>	TOTALS	<u>156</u>	<u>56,940</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>302</u>	<u>331</u>	<u>2,626</u>	<u>3,259</u>	8
9	SNF/PED					9
10	ICF	<u>27,538</u>	<u>13,233</u>		<u>40,771</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,840</u>	<u>13,564</u>	<u>2,626</u>	<u>44,030</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.33%

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

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)

NoneF. 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 2,626Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	254,233	22,879	22,716	299,828		299,828	(297)	299,531		1
2	Food Purchase		195,046		195,046		195,046		195,046		2
3	Housekeeping	136,088	27,740	3,669	167,497		167,497		167,497		3
4	Laundry	79,375	13,534		92,909		92,909		92,909		4
5	Heat and Other Utilities			33	33		33	140,393	140,426		5
6	Maintenance	68,446	12,035	10,378	90,859		90,859	20,283	111,142		6
7	Other (specify):*										7
8	TOTAL General Services	538,142	271,234	36,796	846,172		846,172	160,379	1,006,551		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,039,708	130,082	429,598	2,599,388	(162,428)	2,436,960		2,436,960		10
10a	Therapy					162,428	162,428		162,428		10a
11	Activities	55,931	6,191	950	63,072		63,072		63,072		11
12	Social Services	87,358	43		87,401		87,401		87,401		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,182,997	136,316	437,748	2,757,061		2,757,061		2,757,061		16
	C. General Administration										
17	Administrative	119,373		108,000	227,373		227,373		227,373		17
18	Directors Fees										18
19	Professional Services			89,363	89,363		89,363	(23,725)	65,638		19
20	Dues, Fees, Subscriptions & Promotions			38,937	38,937		38,937	(5,115)	33,822		20
21	Clerical & General Office Expenses	250,738	13,848	49,917	314,503	(170)	314,333	9,249	323,582		21
22	Employee Benefits & Payroll Taxes			465,180	465,180		465,180		465,180		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,346	4,346	170	4,516		4,516		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							151,566	151,566		26
27	Other (specify):* contrib			825	825		825	(825)			27
28	TOTAL General Administration	370,111	13,848	756,568	1,140,527		1,140,527	131,150	1,271,677		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,091,250	421,398	1,231,112	4,743,760		4,743,760	291,529	5,035,289		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 Four Fountains Convalescent Center #0030304 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			13,199	13,199	13,199	267,161	280,360			30
31	Amortization of Pre-Op. & Org.						4,548	4,548			31
32	Interest			36,906	36,906	36,906	377,909	414,815			32
33	Real Estate Taxes						109,897	109,897			33
34	Rent-Facility & Grounds			925,768	925,768	925,768	(925,768)				34
35	Rent-Equipment & Vehicles			12,619	12,619	12,619		12,619			35
36	Other (specify):*										36
37	TOTAL Ownership			988,492	988,492	988,492	(166,253)	822,239			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		75,219	11,249	86,468	86,468		86,468			39
40	Barber and Beauty Shops	24,876	891		25,767	25,767		25,767			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,510	85,510	85,510		85,510			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	24,876	76,110	96,759	197,745	197,745		197,745			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,116,126	497,508	2,316,363	5,929,997	5,929,997	125,276	6,055,273			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: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	1		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	(520)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(825)	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	(4,595)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see pg 5A	(21,843)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,080)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	153,356	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 153,356		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 125,276		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Four Fountains Convalescent Center

ID# 0030304

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Care related legal	\$ (23,725)	19	1
2	To adjust real estate taxes to actual paid	1,882	33	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	(21,843)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(297)	0	0	0	0	0	0	0	0	0	0	(297)	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	140,393	0	0	0	0	0	0	0	0	0	140,393	5
6	Maintenance	0	20,283	0	0	0	0	0	0	0	0	0	20,283	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(297)	160,676	0	160,379	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,725)	0	0	0	0	0	0	0	0	0	0	(23,725)	19
20	Fees, Subscriptions & Promotions	(5,115)	0	0	0	0	0	0	0	0	0	0	(5,115)	20
21	Clerical & General Office Expenses	0	9,249	0	0	0	0	0	0	0	0	0	9,249	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	151,566	0	0	0	0	0	0	0	0	0	151,566	26
27	Other (specify):*	(825)	0	0	0	0	0	0	0	0	0	0	(825)	27
28	TOTAL General Administration	(29,665)	160,815	0	131,150	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,962)	321,491	0	291,529	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	267,161	0	0	0	0	0	0	0	0	0	267,161	30
31	Amortization of Pre-Op. & Org.	0	4,548	0	0	0	0	0	0	0	0	0	4,548	31
32	Interest	0	377,909	0	0	0	0	0	0	0	0	0	377,909	32
33	Real Estate Taxes	1,882	108,015	0	0	0	0	0	0	0	0	0	109,897	33
34	Rent-Facility & Grounds	0	(925,768)	0	0	0	0	0	0	0	0	0	(925,768)	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	1,882	(168,135)	0	(166,253)	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)	(28,080)	153,356	0	125,276	45								

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			South Belt LLC	St. Louis	Real Estate

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	5 Utilities	\$	South Belt LLC	0.00%	\$ 140,393	\$ 140,393
2	V	6 Repairs and Maint		South Belt LLC	0.00%	20,283	20,283
3	V	21 Telephone, office expenses		South Belt LLC	0.00%	9,249	9,249
4	V	26 Insurance		South Belt LLC	0.00%	151,566	151,566
5	V	30 Depreciation		South Belt LLC	0.00%	267,161	267,161
6	V	31 Amortization finance fees		South Belt LLC	0.00%	4,548	4,548
7	V	32 Interest		South Belt LLC	0.00%	377,909	377,909
8	V	33 Real Estate Taxes		South Belt LLC	0.00%	108,015	108,015
9	V	34 Rent	925,768				(925,768)
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 925,768			\$ 1,079,124	\$ * 153,356

* 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: 01/01/07 Ending: 12/31/07

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									\$		1
2											2
3	SEE ATTACHED										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	GMAC		X	Mortgage	\$33,413.59	1/1/05	\$ 5,758,000	\$ 5,613,407	1/1/40	6.1500	\$ 346,762	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Southwest Bank		X	Credit Line	varies	2/1/02	1,000,000		5/1/06	var + 1.25	36,906	6								
7												7								
8												8								
9	TOTAL Facility Related				\$33,413.59		\$ 6,758,000	\$ 5,613,407			\$ 383,668	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,758,000	\$ 5,613,407			\$ 383,668	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,146 Line # 32

* 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 2006 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 2006.

(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>342.46</u>	\$ <u>342.46</u>
2. <u>08-28.0-403-002</u>	<u>LOT/SEC-2 PT LYG S OF RICH CR</u>	\$ <u>105.58</u>	\$ <u>105.58</u>
3. <u>08-28.0-403-003</u>	<u>LOT/SEC-3 PT LYG S OF RICH CR</u>	\$ <u>52.42</u>	\$ <u>52.42</u>
4. <u>08-28.0-403-004</u>	<u>LOT/SEC-4 PT LYG S OF RICH CR</u>	\$ <u>52.42</u>	\$ <u>52.42</u>
5. <u>08-28.0-403-055</u>	<u>LOT/SEC 58 PT LTS 57 & 58</u>	\$ <u>100,923.40</u>	\$ <u>100,923.40</u>
6. <u>08-28.0-403-056</u>	<u>LOT/SEC 58 PT LTS 57 & 58(2701)</u>	\$ <u>8,002.16</u>	\$ <u>8,002.16</u>
7. <u>08-28.0-403-066</u>	<u>LOT/SEC 58 PT LT 58</u>	\$ <u>418.58</u>	\$ <u>418.58</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>109,897.02</u></u>	\$ <u><u>109,897.02</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Four Fountains Convalescent Center

0030304 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,562 B. General Construction Type: Exterior brick Frame steel Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		1985	1972	\$ 3,826,500	\$ 127,550	30	\$ 127,550		\$ 2,739,875	4
5	16		1996	1996	1,641,547	50,053	var	50,053		748,386	5
6											6
7											7
8											8
	Improvement Type**										
9		Building Improvements		1986	23,852	795	30	795		17,093	9
10		Land Improvements		1991	3,947		15				10
11		Building Improvements		1987	10,614	354	30	354		7,255	11
12		Building Improvements		1988	11,664	389	30	389		7,583	12
13		Building Improvements		1989	192,108	6,404	30	6,404		116,901	13
14		Parking Lot Repavement		1989	20,043		15			19,373	14
15		Building Improvements		1990	42,771	1,426	30	1,426		24,953	15
16		Building Improvements		1991	30,378	1,013	30	1,013		17,217	16
17		Land Improvements		1991	1,127		15			1,126	17
18		Building Improvements		1992	11,841	476	30	476		11,839	18
19		Carpeting		1992	318		7			315	19
20		Land Improvements		1992	3,777	140	15	140		9,644	20
21		Building Improvements		1993	1,253		7			1,251	21
22		Land Improvements		1993	2,581	173	15	173		2,541	22
23		Building Improvements		1993	12,614	741	15	741		12,268	23
24		Building Improvements		1994	6,876	459	15	459		6,388	24
25		Building Improvements & Land Improvements		1994	40,120		10			40,118	25
26		Building Improvements		1995	16,869	1,125	15	1,125		14,390	26
27		Building Improvements		1995	33,390		10			33,388	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

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 109	10	\$ 109	\$	\$ 1,303	37
38	Storage Shed	1997	1,002	25	10	25		1,002	38
39	Laundry Water Tank	1997	2,050		10			2,050	39
40	Remodeling	1998	2,090	139	15	139		1,289	40
41	Replace Asphalt	1998	8,525	853	10	853		7,744	41
42	Therapy Kitchen	1999	7,500	500	15	500		4,458	42
43	Roof	1999	112,353	7,490	15	7,490		65,539	43
44	Shower	1999	1,910	127	15	127		1,114	44
45	Therapy Kitchen	1999	2,802	187	15	187		1,603	45
46	Water Heater	1999	9,806	654	15	654		5,557	46
47	Safe Stride Slip Resistant Floor	1999	480	32	15	32		259	47
48	Asphalt	2000	2,765	138	20	138		1,048	48
49	Sign Lettering	2000	900	45	20	45		338	49
50	Fire Suppression System, remodeling	2000	24,431	1,842	15	1,842		13,349	50
51									51
52	New lighting and fixtures	2001	6,360	424	15	424		2,791	52
53	New drains hall 100	2001	4,843	323	15	323		2,260	53
54	Day room remodel	2001	5,671	378	15	378		2,426	54
55	Dining room remodel hall 500	2001	12,079	805	15	805		5,167	55
56	Ansul system hookup	2001	1,900	127	10	127		887	56
57	Wallpaper, plaster,door	2002	8,146	543	15	543		2,951	57
58	Flooring	2003	480	32	5	32		160	58
59	Boiler and circuits	2003	4,900	327	10	327		1,568	59
60	Signage	2003	1,075	72	15	72		311	60
61	Storage	2003	2,835	284	15	284		1,349	61
62	Sprinklers	2004	1,108	74	15	74		277	62
63	Hall improvements/Metal door	2004	4,210	281	15	281		1,022	63
64	Asphalt	2004	4,155	208	20	208		675	64
65	Metal Doors	2005	1,048	70	15	70		204	65
66	Air conditioning	2005	20,057	1,337	15	1,337		3,566	66
67	Wall prep, patching, remodeling	2005	22,485	1,499	15	1,499		3,195	67
68	Windows	2005	67,837	4,522	15	4,522		9,422	68
69	Bathroom fixtures	2005	2,076	139	15	139		288	69
70	TOTAL (lines 4 thru 69)		\$ 6,283,372	\$ 214,684		\$ 214,684	\$	\$ 3,977,076	70

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

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
1	Totals from Page 12A, Carried Forward		\$ 6,283,372	\$ 214,684		\$ 214,684	\$	\$ 3,977,076	1
2	Fireproofing Insulation	2005	19,258	1,284	15	1,284		2,675	2
3	Electrical fixtures and wiring	2005	4,836	323	15	323		672	3
4	Roof Top Air Conditioner	2005	4,898	490	10	490		1,102	4
5	Sprinklers	2005	4,510	451	10	451		977	5
6	Sidewalks	2005	5,700	285	20	285		594	6
7	Fencing	2005	3,965	198	20	198		512	7
8	Roof Top Air Conditioner	2005	5,840	584	10	584		1,265	8
9	Drywall and wall repair	2006	18,717	1,248	15	1,248		2,496	9
10	Fire system upgrades and wiring	2006	6,502	433	15	433		867	10
11	New Toilets and plumbing	2006	19,128	1,275	15	1,275		2,550	11
12	New carpeting	2006	35,102	2,340	15	2,340		4,680	12
13	New Door	2006	1,208	81	15	81		134	13
14	Painting and wallpapering	2006	206,903	13,794	15	13,794		27,587	14
15	Window treatments	2006	13,396	893	15	893		1,786	15
16	Water proofing	2007	2,426	121	15	121		121	16
17	Heating/cooling	2007	2,146	190	10	190		190	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	TOTAL (lines 1 thru 33)		\$ 6,637,907	\$ 238,674		\$ 238,674	\$	\$ 4,025,284	34

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

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 586,062	\$ 41,415	\$ 41,415	\$	5-15	\$ 217,813	71
72	Current Year Purchases	4,117	271	271		10	271	72
73	Fully Depreciated Assets	1,255,374					1,255,374	73
74								74
75	TOTALS	\$ 1,845,553	\$ 41,686	\$ 41,686	\$		\$ 1,473,458	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 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,069,445	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 280,360	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 280,360	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)	\$ 5,498,742	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	1,332	\$ 50,789	\$ 50	1,332	\$ 50,839	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		242	10,724	12	242	10,736	2
3	Licensed Recreational Therapist	10A-3	hrs		3,031	100,545	306	3,031	100,851	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	39-2	# of prescrpts				75,219		75,219	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray,Oxygen	39-2,3				11,249			11,249	13
14	TOTAL			\$	4,605	\$ 173,307	\$ 75,587	4,605	\$ 248,894	14

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

Facility Name & ID Number Four Fountains Convalescent Center# 0030304Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 231,894	\$ 235,990	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 25,053)	1,212,352	1,212,352	3
4	Supply Inventory (priced at cost)	39,599	39,599	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,376	22,376	6
7	Other Prepaid Expenses		434,798	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,506,221	\$ 1,945,115	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		590,140	13
14	Buildings, at Historical Cost		6,602,960	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	346,439	1,876,345	16
17	Accumulated Depreciation (book methods)	(321,156)	(5,498,743)	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): <u>cap loan costs net</u>		145,424	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,283	\$ 3,716,126	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,531,504	\$ 5,661,241	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 304,375	\$ 486,349	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,830	152,830	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,906	5,906	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		28,769	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>accrued Mgmt fees/due to LLC</u>	848,944	655,588	36
37	<u>Distributions payable</u>	35,795	35,795	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,347,850	\$ 1,365,237	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	920,422	920,422	39
40	Mortgage Payable		5,613,407	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 920,422	\$ 6,533,829	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,268,272	\$ 7,899,066	46
47	TOTAL EQUITY(page 18, line 24)	\$ (736,768)	\$ (2,237,825)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,531,504	\$ 5,661,241	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,782,863)	1
2	Restatements (describe):		2
3	prior period adjustment	775	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,782,088)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(455,737)	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)	\$ (455,737)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,237,825)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Four Fountains Convalescent Center

0030304

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 5,084,404	1
2	Discounts and Allowances for all Levels	(91,512)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,992,892	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	402,918	6
7	Oxygen	14,183	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 417,101	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,058	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	118,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,629	19
20	Radiology and X-Ray	2,600	20
21	Other Medical Services	39,459	21
22	Laundry	825	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210,281	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,951	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,951	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>misc</u>	391	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 391	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,627,616	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,006,848	31
32	Health Care	2,757,061	32
33	General Administration	1,301,342	33
B. Capital Expense			
34	Ownership	820,357	34
C. Ancillary Expense			
35	Special Cost Centers	112,235	35
36	Provider Participation Fee	85,510	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,083,353	40
41	Income before Income Taxes (line 30 minus line 40)**	(455,737)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (455,737)	43

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

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

consolidated return

*** 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: 01/01/07

Ending: 12/31/07

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	1,860	1,900	\$ 48,027	\$ 25.28	1
2	Assistant Director of Nursing	1,023	1,023	49,173	48.07	2
3	Registered Nurses	13,481	15,556	379,405	24.39	3
4	Licensed Practical Nurses	25,173	26,873	533,792	19.86	4
5	CNAs & Orderlies	83,819	88,127	984,702	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,467	4,844	44,609	9.21	8
9	Activity Director	5,499	5,881	55,931	9.51	9
10	Activity Assistants					10
11	Social Service Workers	3,865	4,711	87,358	18.54	11
12	Dietician	1,200	1,401	23,855	17.03	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,962	27,228	230,378	8.46	15
16	Dishwashers					16
17	Maintenance Workers	4,123	4,431	68,446	15.45	17
18	Housekeepers	13,229	14,410	136,088	9.44	18
19	Laundry	10,435	10,904	79,375	7.28	19
20	Administrator	1,872	1,920	72,548	37.79	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	46,825	45.02	22
23	Office Manager					23
24	Clerical	16,922	17,620	250,738	14.23	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)	1,785	1,879	24,876	13.24	33
34	TOTAL (lines 1 - 33)	215,755	229,748	\$ 3,116,126 *	\$ 13.56	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	206	\$ 4,306	L1 C3	35
36	Medical Director	as needed	7,200	L9C3	36
37	Medical Records Consultant	16	640	L10C3	37
38	Nurse Consultant	252	7,753	L10C3	38
39	Pharmacist Consultant	18	720	L10C3	39
40	Physical Therapy Consultant	182 +monthly	35,813	L10C3	40
41	Occupational Therapy Consultant	monthly	14,400	L10C3	41
42	Respiratory Therapy Consultant	31 + monthly	6,205	L10C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	492	\$ 77,037		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	3,505	101,308		51
52	Certified Nurse Assistants/Aides	5,488	98,834		52
53	TOTAL (lines 50 - 52)	8,993	\$ 200,142		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 8781
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,409 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 during this cost report period. \$ 85,510
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? n/a 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?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.