

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME# 0028472 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>52</u>	Skilled (SNF)	<u>52</u>	<u>19,032</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>31</u>	Intermediate (ICF)	<u>31</u>	<u>11,346</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>83</u>	TOTALS	<u>83</u>	<u>30,378</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>1,407</u>	<u>1,407</u>	8
9	SNF/PED					9
10	ICF	<u>12,713</u>	<u>11,196</u>		<u>23,909</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,713</u>	<u>11,196</u>	<u>1,407</u>	<u>25,316</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.34%

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 08/01/72

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 18 and days of care provided 1,407Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: _____

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

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOM** # **0028472** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	150,216	8,798	5,103	164,117		164,117		164,117		1
2	Food Purchase		112,918		112,918	(10,159)	102,759	(482)	102,277		2
3	Housekeeping	84,822	11,804		96,626		96,626		96,626		3
4	Laundry	43,628	9,117		52,745		52,745		52,745		4
5	Heat and Other Utilities			98,153	98,153		98,153		98,153		5
6	Maintenance	25,593	21,011	114,112	160,716		160,716	(64,207)	96,509		6
7	Other (specify):*										7
8	TOTAL General Services	304,259	163,648	217,368	685,275	(10,159)	675,116	(64,689)	610,427		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	920,679	33,987	1,977	956,643	(2,840)	953,803		953,803		10
10a	Therapy			94	94		94		94		10a
11	Activities	48,421	2,144	2,062	52,627		52,627		52,627		11
12	Social Services	24,831		2,062	26,893		26,893		26,893		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	993,931	36,131	6,195	1,036,257	(2,840)	1,033,417		1,033,417		16
	C. General Administration										
17	Administrative	92,223			92,223		92,223		92,223		17
18	Directors Fees										18
19	Professional Services			152,045	152,045		152,045		152,045		19
20	Dues, Fees, Subscriptions & Promotions			6,546	6,546		6,546	(2,562)	3,984		20
21	Clerical & General Office Expenses	27,087	8,208	12,651	47,946		47,946	(4,933)	43,013		21
22	Employee Benefits & Payroll Taxes			150,423	150,423	48,694	199,117		199,117		22
23	Inservice Training & Education			100	100		100		100		23
24	Travel and Seminar			4,727	4,727		4,727		4,727		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,196	79,196	(35,695)	43,501		43,501		26
27	Other (specify):*										27
28	TOTAL General Administration	119,310	8,208	405,688	533,206	12,999	546,205	(7,495)	538,710		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,417,500	207,987	629,251	2,254,738		2,254,738	(72,184)	2,182,554		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 THREE SPRINGS LODGE NURSING HOME #0028472 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			35,423	35,423		35,423	25,852	61,275			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							17,701	17,701			33
34	Rent-Facility & Grounds			114,000	114,000		114,000	(114,000)				34
35	Rent-Equipment & Vehicles			1,016	1,016		1,016		1,016			35
36	Other (specify):*											36
37	TOTAL Ownership			150,439	150,439		150,439	(70,447)	79,992			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,260	103,848	168,108		168,108		168,108			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,568	45,568		45,568		45,568			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		64,260	149,416	213,676		213,676		213,676			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,417,500	272,247	929,106	2,618,853		2,618,853	(142,631)	2,476,222			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 THREE SPRINGS LODGE NURSING HOME

0028472

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	9,494	30		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	(482)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,686)	21		18
19	Entertainment				19
20	Contributions	(247)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,510)	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	(64,259)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,690)		\$	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)	(79,941)	SCHVII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (79,941)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (142,631)		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						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

STATE OF ILLINOIS
THREE SPRINGS LODGE NURSING HOME

Report Period Beginning: 01/01/2008
 Ending: 12/31/2008

ID# 0028472

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	LINE 29 DETAIL OF OTHER ADJUSTMENTS	\$	1
2			2
3	ELIMINATE LIONS CLUB DUES	(52)	20 3
4	DEFERRED PAINTING AMORT. SCH XIX	511	6 4
5	ROOF EXPENSED FOR TAXES	(64,718)	6 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	(64,259)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**# **0028472**

Report Period Beginning:

01/01/2008

Ending:

12/31/2008**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	(482)	0	0	0	0	0	0	0	0	0	0	(482)	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	(64,207)	0	0	0	0	0	0	0	0	0	0	(64,207)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(64,689)	0	0	0	0	0	0	0	0	0	0	(64,689)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,562)	0	0	0	0	0	0	0	0	0	0	(2,562)	20
21	Clerical & General Office Expenses	(4,933)	0	0	0	0	0	0	0	0	0	0	(4,933)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,495)	0	0	0	0	0	0	0	0	0	0	(7,495)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,184)	0	0	0	0	0	0	0	0	0	0	(72,184)	29

STATE OF ILLINOIS

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME

0028472

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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	9,494	16,358	0	0	0	0	0	0	0	0	0	25,852	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	17,701	0	0	0	0	0	0	0	0	0	17,701	33
34	Rent-Facility & Grounds	0	(114,000)	0	0	0	0	0	0	0	0	0	(114,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,494	(79,941)	0	(70,447)	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)	(62,690)	(79,941)	0	(142,631)	45								

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
VIRGINIA ROWOLD	25					
SUSAN KRUEGER	25					
MARY ANN CHILDERS	25					
TRACEY WELGE	25					

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	30 DEPRECIATION	\$	WELGE FAMILY LAND TRUST	100.00%	\$ 16,358	\$ 16,358
2	V	34 RENT	114,000	WELGE FAMILY LAND TRUST	100.00%		(114,000)
3	V	33 R E TAXES		WELGE FAMILY LAND TRUST	100.00%	17,701	17,701
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 114,000			\$ 34,059	\$ * (79,941)

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	KENNETH ROWOLD	ADMINISTRATOR	administrative	0.00		40	100.00	SALARY	\$ 92,223	L17/C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,223		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 THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOM** # **0028472** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	NONE																			
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 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.)		\$ 17,701	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 17,701	3
4. Real Estate Tax accrual used for 2008 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.		\$ 17,701	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	16,738	8
	2004	16,889	9
	2005	17,149	10
	2006	17,586	11
	2007	17,701	12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THREE SPRINGS LODGE NURSING HOME COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0028472

CONTACT PERSON REGARDING THIS REPORT ROGER BAGLEY

TELEPHONE (618)549-8331 FAX #: (618)549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>18-162-006-50</u>	<u>231/20 PT SW SW 3.0 AC</u>	\$ <u>17,701.02</u>	\$ <u>17,701.02</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>17,701.02</u>	\$ <u>17,701.02</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 THREE SPRINGS LODGE NURSING HOME

0028472 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,688 B. General Construction Type: Exterior MASONRY Frame STEEL & MASONRY 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).

NONE

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>NURSING HOME IS ON</u>			\$	1
2	<u>OWNER'S FARM LAND</u>				2
3	TOTALS			\$	3

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**# **0028472**

Report Period Beginning:

01/01/2008

Ending:

12/31/2008**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	83		1972	1972	\$ 433,938	\$	40	\$ 10,848	\$ 10,848	\$ 395,046	4
5			1972	1972	225,462		20			225,462	5
6			1982	1982	22,500		20			22,500	6
7			1972	1972	(24,888)					(24,888)	7
8			2003	2003	383,854		20	19,193	19,193	105,561	8
Improvement Type**											
9		SPRINKLER SYSTEM		1975	1,198		20			1,198	9
10		VARIOUS (SPRINKLER & NURSE CALLS)		1976	5,911		10			5,911	10
11		REMODELING / LAUNDRY REMODELING		1974	1,956		10			1,956	11
12		REMODELING / LAUNDRY REMODELING		1975	413		10			413	12
13		ELECTRICAL		1973	399		20			399	13
14		FREEZER / BOILER		1981	10,608		10			10,608	14
15		SHOWER WALLS		1982	7,728		10			7,728	15
16		SHOWER WALLS		1983	9,279		10			9,279	16
17		PUMPS & EXHAUST		1984	3,032		10			3,032	17
18		FREEZER REPAIRS		1986	1,104		10			1,104	18
19		1 ROOFTOP A/C UNIT		1987	9,372		10			9,372	19
20		TELEPHONE SYSTEM		1987	2,794		2			2,794	20
21		STORAGE SHED		1988	11,422	363	20	287	(76)	11,422	21
22		LANDSCAPING		1988	1,998		10			1,998	22
23		INTERIOR DECORATING		1990	11,575	368	15		(368)	11,575	23
24		SMOKE DETECTORS		1990	1,764		15			1,764	24
25		CUBICLE TRACK		1990	3,804	121	20	190	69	3,515	25
26		DRAIN LINES ON DOWNSPOUTS		1990	928		15			928	26
27		CONCRETE PAD		1991	2,088		20	104	104	1,820	27
28		ROOFTOP A/C UNIT		1991	18,780	597	10		(597)	18,780	28
29		NEW ROOF		1991	60,596		20	3,030	3,030	53,025	29
30		SHOWER ROOM RENNOVATIONS		1992	5,465		15			5,465	30
31		ADDITION TO PHONE SYSTEM		1992	538		20	27	27	445	31
32		REMODEL PATIENT ROOM		1993	3,666	94	15	128	34	3,666	32
33		HOT WATER HEATER		1994	2,870		15	191	191	2,770	33
34		PARKING LOT REDONE		1995	21,259	1,417	15	1,417		19,130	34
35		PARKING LOT BUMPERS		1996	654	44	15	44		550	35
36		INSTALL CEILING FANS		1996	1,149		5			1,149	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 **THREE SPRINGS LODGE NURSING HOME**# **0028472**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	REPAIR SEWER LINE & REPLACE KITCHEN SINK DRAINS	1997	\$ 3,112	\$ 184	15	\$ 207	\$ 23	\$ 2,381	37
38	TILE DINNING ROOM	1998	628		15	42	42	441	38
39	SEAL & STRIPE PARKING LOT	1999	1,764		7			1,764	39
40	REPAIR EXISTING WATER LINE	2001	4,057	271	15	270	(1)	2,025	40
41	PUT ROCK & EDGING AROUND BUILDING	2001	2,661	186	10	266	80	1,995	41
42	rip out "c" hall bathroom and replace everything in it	2002	21,659	542	15	1,444	902	9,386	42
43	including new floor, walls, blumbing, ceiling, lights, all								43
44	new sink, toilet, and 2 showers								44
45	NEW COMPRESOR ON ROOF TOP UNIT	2003	2,903		15	194	194	1,067	45
46	tear out resident shower room and replace everything in it	2006	29,295	2,441	12	2,441		6,103	46
47	including new floor, plumbing, showers, with new								47
48	SIDEWALKS, PATIO, & LANDSCAPING	2006	23,474	1,565	15	1,565		3,912	48
49	SPRINKLER BACKFLOW PREVENTOR	2006	6,143	512	12	512		1,280	49
50	tear out nurses station and put new cabinets, counter tops	2007	18,991	1,266	12	1,583	317	2,375	50
51	med room, floor, and everything started 2006 done 2007								51
52	SIDEWALK SECURITY LIGHTING	2007	3,877	259	15	258	(1)	387	52
53	NEW SIGNS FOR THREE SPRINGS	2007	2,039	291	10	204	(87)	306	53
54	shower rooms (2) moved wall, broke out concrete floor & moved	2008	29,922	15,709	15	997	(14,712)	997	54
55	toilet drains, new faucets shower&tub, install ceramic tile								55
56	on walls & floor								56
57	PARKING LOT ADDITION	2008	17,013	567	15	567		567	57
58	MOSAIC FLOORS IN BATHROOMS	2008	6,669	3,501	15	222	(3,279)	222	58
59	NEW ROOF (all but new addition, a-wing, & flat roof)	2008	64,718		10	3,236	3,236	3,236	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,482,141	\$ 30,298		\$ 49,467	\$ 19,169	\$ 953,921	70

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	\$ 96,219	\$ 705	\$ 11,442	\$ 10,737	various	\$ 71,868	71
72	Current Year Purchases	4,420	4,420	366	(4,054)	5-10 years	366	72
73	Fully Depreciated Assets	183,591				various	183,591	73
74								74
75	TOTALS	\$ 284,230	\$ 5,125	\$ 11,808	\$ 6,683		\$ 255,825	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)	\$ 1,766,371	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,423	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,275	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,852	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,209,746	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 1,016 Description: STORAGE (188) DISHMACHINE(828)

(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 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><u>we only hire trained aides</u></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	39/3; 39/2	hrs	\$	684	\$ 40,078	\$ 90	684	\$ 40,168	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		56	4,770		56	4,770	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		665	47,555	313	665	47,868	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				36,205		36,205	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	med supplies, oxygen, iv's, tubefeeding Other (specify): lab, xray, other ancil	39/2 39/3				11,445	27,652		39,097	13
14	TOTAL			\$	1,405	\$ 103,848	\$ 64,260	1,405	\$ 168,108	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 THREE SPRINGS LODGE NURSING HOME# 0028472Report Period Beginning: 01/01/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008

(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	\$ 55,908	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	772,497		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	69,455		5
6	Prepaid Insurance	5,651		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Est Taxes Deposited</u>	52,000		9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 955,511	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	281,513		15
16	Equipment, at Historical Cost	290,465		16
17	Accumulated Depreciation (book methods)	(422,195)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 149,783	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,105,294	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 56,851	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,448		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,195		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>401K Liability</u>	17,645		36
37	<u>Accrued License Bed Tax</u>	11,454		37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 165,593	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 165,593	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 939,701	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,105,294	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 924,410	1
2	Restatements (describe):		2
3	2007 State Taxes recorded	(934)	3
4	2007 Federal Taxes recorded	(51,273)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 872,203	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	67,498	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)	\$ 67,498	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)	\$ 939,701	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/2008Ending: 12/31/2008**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	\$ 2,382,326	1
2	Discounts and Allowances for all Levels	80,722	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,463,048	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	186,000	6
7	Oxygen	27,505	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 213,505	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,810	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,810	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,988	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,988	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,686,351	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	685,275	31
32	Health Care	1,036,257	32
33	General Administration	533,206	33
B. Capital Expense			
34	Ownership	150,439	34
C. Ancillary Expense			
35	Special Cost Centers	168,108	35
36	Provider Participation Fee	45,568	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,618,853	40
41	Income before Income Taxes (line 30 minus line 40)**	67,498	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 67,498	43

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

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

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

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

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**

0028472

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

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	1,928	2,120	\$ 49,565	\$ 23.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,788	4,586	93,939	20.48	3
4	Licensed Practical Nurses	14,748	16,580	274,710	16.57	4
5	CNAs & Orderlies	43,392	50,703	502,465	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,965	3,527	48,421	13.73	9
10	Activity Assistants					10
11	Social Service Workers	1,825	1,983	24,831	12.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,905	2,172	35,948	16.55	14
15	Cook Helpers/Assistants	10,236	12,432	114,268	9.19	15
16	Dishwashers					16
17	Maintenance Workers	1,840	2,013	25,593	12.71	17
18	Housekeepers	7,542	8,674	84,822	9.78	18
19	Laundry	4,231	4,558	43,628	9.57	19
20	Administrator	2,032	2,080	92,223	44.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,644	1,953	27,087	13.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,076	113,381	\$ 1,417,500 *	\$ 12.50	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	94	\$ 5,103	1/3	35
36	Medical Director				36
37	Medical Records Consultant		1,200	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	777	10/3	39
40	Physical Therapy Consultant	2	94	10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	2,062	11/3	44
45	Social Service Consultant	27	2,062	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	198	\$ 11,298		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	PAINTING	2004	\$ 1,871	3	\$ 624	\$ 624	\$ 311	\$	\$	\$	\$	\$	\$
2	PAINTING	2005	3,061	3	510	1,020	1,020	511					
3													
4													
5													
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17													
18													
19													
20	TOTALS		\$ 4,932		\$ 1,134	\$ 1,644	\$ 1,331	\$ 511	\$	\$	\$	\$	\$

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 7.5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A 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. \$ 45,568
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. \$ 12,999 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? NA/
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

THREE SPRINGS LODGE NURSING HOME INC.
 RECLASS FOR PGS 3&4 COLUMN 5 DPA COST REPORT
 ID # 0028472
 12/31/2008

COL 5 LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	12999	
2	FOOD PURCHASES		12999
	RECL COST OF EMPLOYEE MEALS		
2	FOOD PURCHASES	2840	
10	NURSING SUPPLIES		2840
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	35695	
26	INSURANCE		35695
	RECL WORKER'S COMP INSURANCE		