

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME

0028472 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,315	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			1,382	1,382		8
9	SNF/PED						9
10	ICF	11,690	10,450		22,140		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	11,690	10,450	1,382	23,522		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.64%

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)
NONE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 08/01/72

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 1,382

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 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: **01/01/2009** Ending: **12/31/2009**

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	154,784	7,824	5,060	167,668		167,668		167,668		1
2	Food Purchase		107,811		107,811	(8,556)	99,255	(483)	98,772		2
3	Housekeeping	88,139	13,620		101,759		101,759		101,759		3
4	Laundry	45,760	8,781		54,541		54,541		54,541		4
5	Heat and Other Utilities			81,053	81,053		81,053		81,053		5
6	Maintenance	27,033	26,377	56,696	110,106		110,106		110,106		6
7	Other (specify):*										7
8	TOTAL General Services	315,716	164,413	142,809	622,938	(8,556)	614,382	(483)	613,899		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	899,957	32,831	3,175	935,963	(4,019)	931,944		931,944		10
10a	Therapy			47	47		47		47		10a
11	Activities	35,578	1,865	2,220	39,663		39,663		39,663		11
12	Social Services	25,844		2,219	28,063		28,063		28,063		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	961,379	34,696	7,661	1,003,736	(4,019)	999,717		999,717		16
	C. General Administration										
17	Administrative	83,726			83,726		83,726		83,726		17
18	Directors Fees										18
19	Professional Services			151,159	151,159		151,159		151,159		19
20	Dues, Fees, Subscriptions & Promotions			14,386	14,386		14,386	(11,251)	3,135		20
21	Clerical & General Office Expenses	28,481	7,562	15,145	51,188		51,188	(10,206)	40,982		21
22	Employee Benefits & Payroll Taxes			145,956	145,956	45,501	191,457		191,457		22
23	Inservice Training & Education			427	427		427		427		23
24	Travel and Seminar			5,726	5,726		5,726		5,726		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,817	93,817	(32,926)	60,891		60,891		26
27	Other (specify):*										27
28	TOTAL General Administration	112,207	7,562	426,616	546,385	12,575	558,960	(21,457)	537,503		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,389,302	206,671	577,086	2,173,059		2,173,059	(21,940)	2,151,119		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: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			19,889	19,889		19,889	45,660	65,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			620	620		620		620			32
33	Real Estate Taxes							18,538	18,538			33
34	Rent-Facility & Grounds			186,000	186,000		186,000	(186,000)				34
35	Rent-Equipment & Vehicles			1,066	1,066		1,066		1,066			35
36	Other (specify):*											36
37	TOTAL Ownership			207,575	207,575		207,575	(121,802)	85,773			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,483	106,818	177,301		177,301		177,301			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				45,443		45,443		45,443			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		70,483	106,818	222,744		222,744		222,744			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,389,302	277,154	891,479	2,603,378		2,603,378	(143,742)	2,459,636			45

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

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	29,302	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	(483)	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	(10,051)	21		18
19	Entertainment				19
20	Contributions	(155)	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	(11,199)	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	(52)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,362		\$	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)	(151,104)	SCHVII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (151,104)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (143,742)		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

ID# 0028472

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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				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	(52)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(483)	0	0	0	0	0	0	0	0	0	0	(483)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(483)	0	0	0	0	0	0	0	0	0	0	(483)	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	(11,251)	0	0	0	0	0	0	0	0	0	0	(11,251)	20
21	Clerical & General Office Expenses	(10,206)	0	0	0	0	0	0	0	0	0	0	(10,206)	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	(21,457)	0	0	0	0	0	0	0	0	0	0	(21,457)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,940)	0	0	0	0	0	0	0	0	0	0	(21,940)	29

STATE OF ILLINOIS

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

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	29,302	16,358	0	0	0	0	0	0	0	0	0	45,660	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	18,538	0	0	0	0	0	0	0	0	0	18,538	33
34	Rent-Facility & Grounds	0	(186,000)	0	0	0	0	0	0	0	0	0	(186,000)	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	29,302	(151,104)	0	(121,802)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	7,362	(151,104)	0	0	0	0	0	0	0	0	0	(143,742)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 DEPRECIATION	\$	WELGE FAMILY LAND TRUST	100.00%	\$ 16,358	\$ 16,358	1
2	V	34 RENT	186,000	WELGE FAMILY LAND TRUST	100.00%		(186,000)	2
3	V	33 R E TAXES		WELGE FAMILY LAND TRUST	100.00%	18,538	18,538	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 186,000			\$ 34,896	\$ * (151,104)	14

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

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOM** # **0028472** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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	\$ 83,726	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	\$ 83,726		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: 01/01/2009 Ending: 2/31/2009

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

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

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

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:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
Working Capital												
6	CHESTER NATIONAL BANK		X	OPERATING CASH							620	6
7	(line of credit loan fee)											7
8												8
9	TOTAL Facility Related						\$	\$			\$ 620	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$ 620	15

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

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

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

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</p>			
1. Real Estate Tax accrual used on 2008 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.)		\$ 18,538	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 18,538	3
4. Real Estate Tax accrual used for 2009 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.		\$ 18,538	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	16,889	8
	2005	17,149	9
	2006	17,586	10
	2007	17,701	11
	2008	18,538	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME

0028472

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME IS ON</u>			\$	<u>1</u>
2	<u>OWNER'S FARM LAND</u>				<u>2</u>
3	TOTALS			\$	3

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	83		1972	1972	\$ 433,938	\$	40	\$ 10,848	\$ 10,848	\$ 405,894	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	124,754	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	362	20		(362)	11,422	21
22		LANDSCAPING		1988	1,998		10			1,998	22
23		INTERIOR DECORATING		1990	11,575	367	15		(367)	11,575	23
24		SMOKE DETECTORS		1990	1,764		15			1,764	24
25		CUBICLE TRACK		1990	3,804	121	20	190	69	3,705	25
26		DRAIN LINES ON DOWNSPOUTS		1990	928		15			928	26
27		CONCRETE PAD		1991	2,088		20	104	104	1,924	27
28		ROOFTOP A/C UNIT		1991	18,780	596	10		(596)	18,780	28
29		NEW ROOF		1991	60,596		20	3,030	3,030	56,055	29
30		SHOWER ROOM RENNOVATIONS		1992	5,465		15			5,465	30
31		ADDITION TO PHONE SYSTEM		1992	538		20	27	27	472	31
32		REMODEL PATIENT ROOM		1993	3,666	94	15		(94)	3,666	32
33		HOT WATE HEATER		1994	2,870		15	100	100	2,870	33
34		PARKING LOT REDONE		1995	21,259	1,417	15	1,417		20,547	34
35		PARKING LOT BUMPERS		1996	654	43	15	44	1	594	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:

01/01/2009 Ending: 12/31/2009

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	\$ 2,588	37
38	TILE DINNING ROOM	1998	628		15	42	42	483	38
39	SEAL & STRIPE PARKING LOT	1999	1,764		7			1,764	39
40	REPAIR EXISTING WATER LINE	2001	4,057	270	15	270		2,295	40
41	PUT ROCK & EDGING AROUND BUILDING	2001	2,661	186	10	266	80	2,261	41
42	rip out "c" hall bathroom and replace everything in it	2002	21,659	541	15	1,444	903	10,830	42
43	including new floor, walls, plumbing, ceiling, lights, all								43
44	new sink, toilet, and 2 showers								44
45	NEW COMPRESSOR ON ROOF TOP UNIT	2003	2,903		15	194	194	1,261	45
46	tear out resident shower room and replace everything in it	2006	29,295	2,441	12	2,441		8,544	46
47	including new floor, pluming, showers, with new								47
48	SIDEWALKS, PATIO, & LANDSCAPING	2006	23,474	1,565	15	1,565		5,477	48
49	SPRINKLER BACKFLOW PREVENTOR	2006	6,143	512	12	512		1,792	49
50	tear out nurses station and put new cabinets, counter tops	2007	18,991	1,266	12	1,583	317	3,958	50
51	med room floor, and everything started 2006 done 2007								51
52	SIDEWALK SECURITY LIGHTING	2007	3,877	258	15	258		645	52
53	NEW SIGNS FOR THREE SPRINGS	2007	2,039	291	10	204	(87)	510	53
54	shower rooms (2) moved wall, broke out concrete floor & moved	2008	29,922	1,421	15	1,995	574	2,992	54
55	toilet drains, new faucets shower & tub, install ceramic tile								55
56	on walls & floor								56
57	PARKING LOT ADDITION	2008	17,013	1,134	15	1,134		1,701	57
58	MOSAIC FLOORS IN BATHROOMS	2008	6,669	317	15	445	128	667	58
59	NEW ROOF (all but new addition, a-wing, & flat roof)	2008	64,718		10	6,472	6,472	9,708	59
60	KITCHEN SEWER REPAIR	2009	50,020	1,119	39	641	(478)	641	60
61	COMPRESSOR ON ROOFTOP UNIT	2009	6,797	234	15	227	(7)	227	61
62	CONCRETE PORCH ENTRANCE	2009	3,639	27	39	46	19	46	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,542,597	\$ 14,766		\$ 54,899	\$ 40,133	\$ 1,008,820	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 91,184	\$ 378	\$ 10,413	\$ 10,035	VARIOUS	\$ 73,192	71
72	Current Year Purchases	4,745	4,745	237	(4,508)	10 YRS	237	72
73	Fully Depreciated Assets	193,046				VARIOUS	193,046	73
74								74
75	TOTALS	\$ 288,975	\$ 5,123	\$ 10,650	\$ 5,527		\$ 266,475	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)	\$ 1,831,572	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,889	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,549	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 45,660	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,275,295	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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: \$ 1,066 Description: STORAGE (188) DISHMACHINE (828) PULSE OXIMETER (50)

(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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$	681	\$ 39,664	\$ 122	681	\$ 39,786	1
2	Licensed Speech and Language Development Therapist	39/3;39/2	hrs		108	8,545	13	108	8,558	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		627	45,470	275	627	45,745	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 prescripts				40,772		40,772	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				13,139	29,301		42,440	13
14	TOTAL			\$	1,416	\$ 106,818	\$ 70,483	1,416	\$ 177,301	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**

0028472

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 42,698	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	454,762		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	391,521		5
6	Prepaid Insurance	5,387		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): EST TAXES DEPOSITED	21,004		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 915,372	\$	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	343,349		15
16	Equipment, at Historical Cost	295,211		16
17	Accumulated Depreciation (book methods)	(442,084)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,476	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,111,848	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 58,934	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,941		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,973		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	401K Liability	15,544		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 119,392	\$	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
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 119,392	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 992,456	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,111,848	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 939,701	1
2	Restatements (describe):		2
3	2008 FEDERAL TAXES RECORDED	(10,326)	3
4	2008 STATE TAXES RECORDED	(6,196)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 923,179	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	69,277	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)	\$ 69,277	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)	\$ 992,456	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME** # **0028472** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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	\$ 2,348,005	1
2	Discounts and Allowances for all Levels	88,639	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,436,644	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	195,420	6
7	Oxygen	34,805	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 230,225	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	1,443	19
20	Radiology and X-Ray	1,847	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,290	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,496	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,496	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)	\$ 2,672,655	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	622,938	31
32	Health Care	1,003,736	32
33	General Administration	546,385	33
B. Capital Expense			
34	Ownership	207,575	34
C. Ancillary Expense			
35	Special Cost Centers	177,301	35
36	Provider Participation Fee	45,443	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,603,378	40
41	Income before Income Taxes (line 30 minus line 40)**	69,277	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 69,277	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: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,008	2,080	\$ 50,526	\$ 24.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,258	3,860	85,172	22.07	3
4	Licensed Practical Nurses	14,834	17,132	274,975	16.05	4
5	CNAs & Orderlies	42,912	48,011	489,284	10.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,253	2,850	35,578	12.48	9
10	Activity Assistants					10
11	Social Service Workers	1,755	1,972	25,844	13.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,901	2,178	37,636	17.28	14
15	Cook Helpers/Assistants	10,464	12,310	117,148	9.52	15
16	Dishwashers					16
17	Maintenance Workers	1,875	2,042	27,033	13.24	17
18	Housekeepers	7,744	8,710	88,139	10.12	18
19	Laundry	4,276	4,515	45,760	10.14	19
20	Administrator	1,960	2,080	83,726	40.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,733	1,972	28,481	14.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,973	109,712	\$ 1,389,302 *	\$ 12.66	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	88	\$ 5,060	1/3	35
36	Medical Director				36
37	Medical Records Consultant		2,400	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	775	10/3	39
40	Physical Therapy Consultant	1	47	10a/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	2,220	11/3	44
45	Social Service Consultant	28	2,219	12/3	45
46	Other(specify)				46
47	purchasing consultant		5	19/3	47
48	billing consultant		1,770	19/3	48
49	TOTAL (lines 35 - 48)	194	\$ 14,496		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
KEN ROWOLD	ADMINISTRATOR	0	\$ 83,726	Workers' Compensation Insurance	\$ 32,926	IDPH License Fee	\$ 996	
				Unemployment Compensation Insurance	9,625	Advertising: Employee Recruitment	511	
				FICA Taxes	106,282	Health Care Worker Background Check	360	
				Employee Health Insurance	4,943	(Indicate # of checks performed 31)		
				Employee Meals	12,575	Patient Background Checks	64	
				Illinois Municipal Retirement Fund (IMRF)*		other adv(11199) lions dues (52)	11,251	
				401K EXPENSES	17,696	corp fee (100) INHAA (100)	200	
				BONUSES	55	Boiler Inspection (100) Notary(10)	110	
				PARTIES, X-MAS, VACCINES, ETC.	7,355	subscriptions	190	
						Eliminate Lions Club Dues	(52)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(11,199)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 83,726	TOTAL (agree to Schedule V, line 22, col.8)	\$ 191,457	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,135	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	2,828
							Seminar Expense	2,898
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 5,726
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
JACK LINK	ACCOUNTANT		\$ 750					
JAMESTOWN MANAGEMENT	MANAGEMENT		143,763					
MES	PURCHASING CONS		5					
INNOVATIVE LTC SOLUTIONS	BILLING CONSULTANT		1,770					
ELVIDGE KELLY	LEGAL		4,671					
ARBEITER & WALKER	LEGAL		200					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 151,159					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13														
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1	PAINTING	2004	\$ 1,871	3	\$ 624	\$ 311	\$	\$	\$	\$	\$	\$														
2	PAINTING	2005	\$ 3,061	3	\$ 1,020	\$ 1,020	\$ 511																			
3																										
4																										
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19																										
20	TOTALS		\$ 4,932		\$ 1,644	\$ 1,331	\$ 511	\$	\$	\$	\$	\$														

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME# 0028472Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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? 10 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. \$ 45,443
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. \$ 12,575 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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
 12/31/2009

COL 5 LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	12575	
2	FOOD PURCHASES		12575
	RECL COST OF EMPLOYEE MEALS		
2	FOOD PURCHASES	4019	
10	NURSING SUPPLIES		4019
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	32926	
26	INSURANCE		32926
	RECL WORKER'S COMP INSURANCE		