FOR BHF USE

LL1

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

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051383

Facility Name: THREE SPRINGS LODGE NURSING HOME

Address: 161 THREE SPRINGS ROAD (Number) CHESTER (City) 62233 (Zip Code)

County: RANDOLPH

Telephone Number: (618)826-3210 **Fax #** (618)826-3821

HFS ID Number:

Date of Initial License for Current Owners: 04/01/2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY
JAMESTOWN MANAGEMENT
Telephone Number: (618)549-8331
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	19,032	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,346	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,378	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,573	1,573	8
9	SNF/PED					9
10	ICF	10,444	9,970		20,414	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,444	9,970	1,573	21,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.38%

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 [X]

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

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 [X] Date 04/01/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,573

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOM # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	149,643	5,988	5,712	161,343		161,343		161,343			1
2	Food Purchase		113,816		113,816	(7,190)	106,626	(527)	106,099			2
3	Housekeeping	85,735	10,412		96,147		96,147		96,147			3
4	Laundry	54,906	5,456		60,362		60,362		60,362			4
5	Heat and Other Utilities			71,599	71,599		71,599		71,599			5
6	Maintenance	29,095	19,349	46,066	94,510		94,510		94,510			6
7	Other (specify):*											7
8	**TOTAL General Services**	319,379	155,021	123,377	597,777	(7,190)	590,587	(527)	590,060			8
	B. Health Care and Programs											
9	Medical Director			400	400		400		400			9
10	Nursing and Medical Records	899,362	30,624	4,354	934,340	(7,100)	927,240		927,240			10
10a	Therapy			1,723	1,723		1,723		1,723			10a
11	Activities	42,380	2,420	1,826	46,626		46,626		46,626			11
12	Social Services	30,212		1,826	32,038		32,038		32,038			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	971,954	33,044	10,129	1,015,127	(7,100)	1,008,027		1,008,027			16
	C. General Administration											
17	Administrative	74,339			74,339		74,339		74,339			17
18	Directors Fees											18
19	Professional Services			168,598	168,598		168,598		168,598			19
20	Dues, Fees, Subscriptions & Promotions			9,095	9,095		9,095	(3,889)	5,206			20
21	Clerical & General Office Expenses	29,759	8,431	5,835	44,025		44,025	(1,024)	43,001			21
22	Employee Benefits & Payroll Taxes			154,089	154,089	47,364	201,453		201,453			22
23	Inservice Training & Education			60	60		60		60			23
24	Travel and Seminar			7,328	7,328		7,328		7,328			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			145,871	145,871	(33,074)	112,797		112,797			26
27	Other (specify):*											27
28	**TOTAL General Administration**	104,098	8,431	490,876	603,405	14,290	617,695	(4,913)	612,782			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,395,431	196,496	624,382	2,216,309		2,216,309	(5,440)	2,210,869			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 #0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,490	99,490		99,490	(36,911)	62,579			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,053	44,053		44,053	(2,458)	41,595			32
33	Real Estate Taxes			19,997	19,997		19,997		19,997			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,673	7,673		7,673		7,673			35
36	Other (specify):*											36
37	**TOTAL Ownership**			171,213	171,213		171,213	(39,369)	131,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,153	167,374	251,527		251,527		251,527			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,849	171,849		171,849		171,849			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		84,153	339,223	423,376		423,376		423,376			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,395,431	280,649	1,134,818	2,810,898		2,810,898	(44,809)	2,766,089			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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(36,911)	30		9
10	Interest and Other Investment Income	(2,458)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(527)	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	(132)	21		18
19	Entertainment				19
20	Contributions	(892)	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	(3,889)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,809)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,809)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

THREE SPRINGS LODGE NURSING HOME

ID# 0051383

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(527)	0	0	0	0	0	0	0	0	0	0	(527)	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**	(527)	0	0	0	0	0	0	0	0	0	0	(527)	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	(3,889)	0	0	0	0	0	0	0	0	0	0	(3,889)	20
21	Clerical & General Office Expenses	(1,024)	0	0	0	0	0	0	0	0	0	0	(1,024)	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**	(4,913)	0	0	0	0	0	0	0	0	0	0	(4,913)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,440)	0	0	0	0	0	0	0	0	0	0	(5,440)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(36,911)	0	0	0	0	0	0	0	0	0	0	(36,911)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,458)	0	0	0	0	0	0	0	0	0	0	(2,458)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,369)	0	0	0	0	0	0	0	0	0	0	(39,369)	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)**	(44,809)	0	0	0	0	0	0	0	0	0	0	(44,809)	45

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
VIRGINIA ROWOLD	50					
KEN ROWOLD	50					

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 [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOI # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	KENNETH ROWOLD	ADMINISTRATOR	administrative	50.00	0	40	100.00	SALARY	$ 74,339	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	$ 74,339		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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X]

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOM # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CHESTER NATIONAL BANK		X	MORTGAGE	$4,074.41	03/31/11	$ 480,000	$ 435,139	04/01/21	0.0600	$ 27,262	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CHESTER NATIONAL BANK		X	OPERATING LINE OF CRED	INT ONLY	03/31/11	200,000	200,000	01/31/14	0.0500	10,167	6
7	CHESTER NATIONAL BANK		X	OPERATING LINE OF CRED	INT ONLY	10/03/12	200,000	50,000	10/03/13	0.0500	6,624	7
8												8
9	TOTAL Facility Related				$4,074.41		$ 880,000	$ 685,139			$ 44,053	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 880,000	$ 685,139			$ 44,053	15

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

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

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 20,215	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.)		$ 19,997	2
3. Under or (over) accrual (line 2 minus line 1).		$ (218)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 20,215	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.		$ 19,997	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	17,701	8
	2008	18,538	9
	2009	18,992	10
	2010	19,718	11
	2011	19,997	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THREE SPRINGS LODGE NURSING HOME COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0051383

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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-162-006-50	231/20 PT SW SW 3.0 AC	$ 19,996.92	$ 19,996.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,996.92	$ 19,996.92

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 and 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	NURSING HOME IS ON			$	1
2	OWNER'S FARM LAND				2
3	TOTALS			$	3

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 14,743	40	$ 6,348	$ (8,395)	$ 433,938	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	182,333	8
	Improvement Type**										
9	SPRINKLER SYSTEM			1972	1,198		20			1,198	9
10	VARIOUS (SPRINKLER AND 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 ROOF TOP 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		20			11,422	21
22	LANDSCAPING			1988	1,998		10			1,998	22
23	INTERIOR DECORATING			1990	11,575		15			11,575	23
24	SMOKE DETECTORS			1990	1,764		15			1,764	24
25	CUBICLE TRACK			1990	3,804		20			3,804	25
26	DRAIN LINES ON DOWNSPOUTS			1990	928		15			928	26
27	CONCRETE PAD			1991	2,088		20			2,088	27
28	ROOFTOP A/C UNIT			9991	18,780		10			18,780	28
29	NEW ROOF			1991	60,596		20			60,596	29
30	SHOWER ROOM RENNOVATIONS			1992	5,465		15			5,465	30
31	ADDITION TO PHONE SYSTEM			1992	538		20	12	12	538	31
32	REMODEL PATIENT ROOM			1993	3,666		15			3,666	32
33	HOT WATER HEATER			1994	2,870		15			2,870	33
34	PARKING LOT REDONE			19995	21,259		15			21,259	34
35	PARKING LOT PUMPERS			1996	654		15			654	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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPAIR SEWER LINE & REPLACE KITCHEN SINK DRAINS	1997	$ 3,112	$	15	$ 110	$ 110	$ 3,112	37
38	TILE DINNING ROOM	1998	628		15	42	42	609	38
39	SEAL & STRIPE PARKING LOT	1999	1,764		7			1,764	39
40	REPAIR EXISTING WATER LINE	2001	4,057		15	270	270	3,105	40
41	PUT ROCK & EDGING AROUND THE BUILDING	2001	2,661		10			2,661	41
42	rip out "c" hall bathroom and replace everything in it	2001	21,659		15	1,444	1,444	15,162	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	1,843	45
46	tear out resident shower room and replace everything in it	2006	29,295		12	2,441	2,441	15,867	46
47	including new floor, plumbing , showers, with new								47
48	SIDEWALKS, PATIO, & LANDSCAPING	2006	23,474		15	1,565	1,565	10,172	48
49	SPRINKLER BACKFLOW PREVENTOR	2006	6,143		12	512	512	3,328	49
50	tear out nurses station and put new cabinets, counter tops	2007	18,991		12	1,583	1,583	8,707	50
51	med room floor, and everthing, started 2006 done 2007								51
52	SIDEWALKS SECURITY LIGHTING	2007	3,877		15	258	258	1,419	52
53	NEW SIGNS FOR THREE SPRINGS	2007	2,039		10	204	204	1,122	53
54	shower room (2) moved wall, broke out concrete floor & moved	2008	29,922		15	1,995	1,995	8,977	54
55	toilet drains, new faucets shower tubs, install cermic tile								55
56	on walls & floor								56
57	PARKING LOT ADDITION	2008	17,013		15	1,134	1,134	5,103	57
58	MOSAIC FLOOR IN BATHROOMS	2008	6,669		15	445	445	2,002	58
59	NEW ROOF (all but new addition, a-wing & flat roof)	2008	64,718		10	6,472	6,472	29,124	59
60	KITCHEN SEWER REPAIR	2009	51,139		39	1,311	1,311	4,574	60
61	COMPRESSOR ON ROOFTOP UNIT	2009	7,031		15	469	469	1,634	61
62	CONCRETE PORCH ENTRANCE	2009	3,666		39	94	94	328	62
63	all rooms & hallway in A wing painted, new chair rails,	2010	25,965		15	1,731	1,731	4,328	63
64	wallpaper, door protectors								64
65	NEW BATHROOM FLOORS IN ALL BATHROOMS	2010	12,976		15	865	865	2,163	65
66	A-HALL ROOF REPAIRS	2011	17,870		10	1,787	1,787	2,681	66
67	apartment renovated - installed tub- removed a/c unit fix wall	2012	2,601	1,348	10	130	(1,218)	130	67
68	FRONT PORCH SPRINKLED	2012	6,195	3,123	15	207	(2,916)	207	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,609,584	$ 19,214		$ 50,816	$ 31,602	$ 1,171,817	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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 93,774	$	$ 8,997	$ 8,997	various	$ 43,398	71
72	Current Year Purchases	18,167	80,276	986	(79,290)	various	986	72
73	Fully Depreciated Assets	250,584				various	250,584	73
74								74
75	TOTALS	$ 362,525	$ 80,276	$ 9,983	$ (70,293)		$ 294,968	75

D. Vehicle Costs. (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	transport residents to	1998 DODGE CARAVAN	2011	$ 8,898	$	$ 1,780	$ 1,780	5	$ 2,670	76
77	doctor's appts									77
78										78
79										79
80	TOTALS			$ 8,898	$	$ 1,780	$ 1,780		$ 2,670	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)	$ 1,981,007	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,490	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 62,579	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (36,911)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,469,455	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.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 7,673 Description: STORAGE (188) DISHMACHINE (780) PATIENT LIFT (978) WOUND VAC (5727)
(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.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   we only hire trained aides

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3;39/2	hrs	$	1,033	$ 61,956	$ 25	1,033	$ 61,981	1
2	Licensed Speech and Language Development Therapist	39/3;39/2	hrs		142	13,209	7	142	13,216	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		1,281	76,064	149	1,281	76,213	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				48,570		48,570	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				16,145	35,402		51,547	13
14	TOTAL			$	2,456	$ 167,374	$ 84,153	2,456	$ 251,527	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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 87,033	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	844,015		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,094		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 958,142	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	601,666		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	274,099		16
17	Accumulated Depreciation (book methods)	(174,698)		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): GOODWILL	44,167		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 770,234	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,728,376	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 67,171	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,825		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,366		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,215		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	15,823		36
37	ACCR OCCUPIED BED TAX	62,600		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 227,000	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	435,139		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LINE OF CREDIT	250,000		43
44	LOAN FROM ROWOLDS	301,818		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 986,957	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,213,957	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 514,419	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,728,376	$	48

***(See instructions.)**

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 439,492	1	
2	Restatements (describe):		2	
3	**RESTATEMENT FOR 2011 ADJUST FOR OCC BED**	(10,517)	3	
4	**TAX AND OWNERSHIP CHANGE IN 2011**		4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 428,975	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	85,444	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)**	$ 85,444	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)**	$ 514,419	24	*

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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,510,287	1
2	Discounts and Allowances for all Levels	53,465	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,563,752	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,500	6
7	Oxygen	25,475	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 320,975	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	4,045	19
20	Radiology and X-Ray	5,112	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,157	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,458	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,458	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)**	$ 2,896,342	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	597,777	31
32	Health Care	1,015,127	32
33	General Administration	603,405	33
	B. Capital Expense		
34	Ownership	171,213	34
	C. Ancillary Expense		
35	Special Cost Centers	251,527	35
36	Provider Participation Fee	171,849	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,810,898	40
41	**Income before Income Taxes (line 30 minus line 40)****	85,444	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 85,444	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,097,457	44
45	Private Pay - Net Inpatient Revenue	1,163,199	45
46	Medicare - Net Inpatient Revenue	294,460	46
47	Other-(specify) PRIOR YEAR ADJUSTMENTS	(1,329)	47
48	Other-(specify) OXIMETER INCOME	9,965	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,563,752	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** NO, 2011 ADJ FOR O BED TAX ON TX IN 2

*** **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 # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,381	3,765	$ 90,289	$ 23.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	404	516	10,196	19.76	3
4	Licensed Practical Nurses	19,807	21,452	356,301	16.61	4
5	CNAs & Orderlies	38,470	41,322	442,576	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,043	3,325	42,380	12.75	9
10	Activity Assistants					10
11	Social Service Workers	1,886	2,089	30,212	14.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,833	2,088	37,655	18.03	14
15	Cook Helpers/Assistants	10,314	11,019	111,988	10.16	15
16	Dishwashers					16
17	Maintenance Workers	2,369	2,520	29,095	11.55	17
18	Housekeepers	7,019	7,582	85,735	11.31	18
19	Laundry	4,254	4,667	54,906	11.76	19
20	Administrator	2,016	2,080	74,339	35.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,538	1,950	29,759	15.26	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)	96,334	104,375	$ 1,395,431 *	$ 13.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	5,712	$ 5,712		35
36	Medical Director		400		36
37	Medical Records Consultant		2,200		37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,154		39
40	Physical Therapy Consultant	18	1,051		40
41	Occupational Therapy Consultant	9	484		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	188		43
44	Activity Consultant	23	1,826		44
45	Social Service Consultant	24	1,826		45
46	Other(specify)				46
47	BILLING CONSULTANT		2,347		47
48					48
49	TOTAL (lines 35 - 48)	5,837	$ 18,188		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEN ROWOLD	ADMINISTRATOR	50%	$ 74,339
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 74,339

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
BIRCHLER-SCHMERBAUCH	ACCOUNTANT	$ 650
ELVIDGE KELLY	LEGAL	3,715
INNOVATIVE SOLUTIONS	BILLING CONSULTANT	2,347
JAMESTOWN MGMT	MANAGEMENT	161,886
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 168,598

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,074
Unemployment Compensation Insurance	18,087
FICA Taxes	106,750
Employee Health Insurance	4,396
Employee Meals	14,290
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	17,903
PARTIES, X-MAS, VACCINES, ETC.	6,953
TOTAL (agree to Schedule V, line 22, col.8)	$ 201,453

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,359
Advertising: Employee Recruitment	397
Health Care Worker Background Check (Indicate # of checks performed 9)	108
Patient Background Checks 72	850
OTHER ADV(ELIM)	3,889
corp fee(349) subscriptions(200)	549
medicare reenroll (523) clia lab(150)	673
INHAA (100) activity assoc (40)	140
DON ASSOC (130)	130
Less: Public Relations Expense	( )
Non-allowable advertising	(3,889)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,206

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,929
Seminar Expense	2,399
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,328

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0051383 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2004	$ 1,871	3	$ 311	$	$	$	$	$	$	$	$
2	PAINTING	2005	3,061	3	1,020	511							
3													
4													
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10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,932		$ 1,331	$ 511	$	$	$	$	$	$	$

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME **#** 0051383 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **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? **11 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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
THREE SPRINGS LODGE NURSING HOME INC. #0028472 CHANGE 4/1/11

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **171,849**
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. $ **14,290** 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 LLC
RECLASS FOR PAGES 3 & 4 COLUMN 5 DPA COST REPORT
ID # 0051383
12/31/2012

COL 5 LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	14290	
2	FOOD PURCHASES		14290
	RECL COST OF EMPLOYEE MEALS		
2	FOOD PURCHASES	7100	
10	NURSING SUPPLIES		7100
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	33074	
26	INSURANCE		33074
	RECL WORKER'S COMP INSURANCE		