

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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.

<p>I. IDPH Facility ID Number: <u>0029322</u></p> <p>Facility Name: <u>FREEPORT REHAB & HLTH CARE CTR</u></p> <p>Address: <u>900 S. KIWANIS DR.</u> <u>FREEPORT</u> <u>61032</u> Number City Zip Code</p> <p>County: <u>STEPHENSON</u></p> <p>Telephone Number: <u>815-235-6196</u> Fax # <u>815-235-5365</u></p> <p>IDPA ID Number: <u>51-0271905</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1985</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u> </u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u> </u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ken Marx, BKD, LLP</u> Telephone Number: <u>314-231-5544</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u> </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2003</u> to <u>6/30/2004</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Junior Foster, THSCLLC, Mgt. Co for</u> (Title) <u>FREEPORT REHAB & HLTH CARE CTR</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Junior Foster, THSCLLC, Mgt. Co for</u> (Title) <u>FREEPORT REHAB & HLTH CARE CTR</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																												

Facility Name & ID Number FREEPORT MANOR

29322 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,338	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	143	TOTALS	143	52,338	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 Public Aid Recipient	4 Private Pay	Other	Total		
8	SNF	22,482	12,926	4,963	40,371	8	
9	SNF/PED	0	0	0		9	
10	ICF	0	0	0		10	
11	ICF/DD	0	0	0		11	
12	SC	0	0	0		12	
13	DD 16 OR LESS	0	0	0		13	
14	TOTALS	22,482	12,926	4,963	40,371	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.14%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/1985

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 143 and days of care provided 4,963

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

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

Facility Name & ID Number **FREEPOR MANOR** # **29322** Report Period Beginning: **7/1/2003** Ending: **6/30/2004**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	184,316	9,477	8,799	202,592		202,592	(3,929)	198,663		1
2	Food Purchase		170,437		170,437		170,437	(748)	169,689		2
3	Housekeeping		18,294	117,264	135,558		135,558		135,558		3
4	Laundry		9,662	78,176	87,838		87,838		87,838		4
5	Heat and Other Utilities			113,949	113,949		113,949		113,949		5
6	Maintenance	43,327	7,587	40,603	91,517		91,517		91,517		6
7	Other (specify):*			9,051	9,051		9,051		9,051		7
8	TOTAL General Services	227,643	215,457	367,842	810,942		810,942	(4,677)	806,265		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,606,167	123,985	7,633	1,737,785		1,737,785		1,737,785		10
10a	Therapy		90	322,241	322,331		322,331		322,331		10a
11	Activities	50,483	1,172	4,433	56,088		56,088		56,088		11
12	Social Services	105,532		2,552	108,084		108,084		108,084		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,762,182	125,247	352,459	2,239,888		2,239,888		2,239,888		16
	C. General Administration										
17	Administrative	68,810			68,810		68,810		68,810		17
18	Directors Fees										18
19	Professional Services			363,405	363,405		363,405	2,237	365,642		19
20	Dues, Fees, Subscriptions & Promotions			26,790	26,790		26,790	(11,368)	15,422		20
21	Clerical & General Office Expenses	59,293	20,613	60,705	140,611		140,611	(45,260)	95,351		21
22	Employee Benefits & Payroll Taxes			366,160	366,160		366,160	9,157	375,317		22
23	Inservice Training & Education			1,613	1,613		1,613	1,146	2,759		23
24	Travel and Seminar			7,289	7,289		7,289	4,725	12,014		24
25	Other Admin. Staff Transportation			4,658	4,658		4,658		4,658		25
26	Insurance-Prop.Liab.Malpractice			152,892	152,892		152,892		152,892		26
27	Other (specify):*										27
28	TOTAL General Administration	128,103	20,613	983,512	1,132,228		1,132,228	(39,363)	1,092,865		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,117,928	361,317	1,703,813	4,183,058		4,183,058	(44,040)	4,139,018		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			191,528	191,528		191,528		191,528		30
31	Amortization of Pre-Op. & Org.			23,103	23,103		23,103	(23,103)	(0)		31
32	Interest			620,795	620,795		620,795	(723)	620,072		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,357	3,357		3,357		3,357		35
36	Other (specify):*										36
37	TOTAL Ownership			838,783	838,783		838,783	(23,826)	814,957		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		208,491	35,444	243,935		243,935	39	243,974		39
40	Barber and Beauty Shops		66		66		66		66		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			78,508	78,508		78,508		78,508		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		208,557	113,952	322,509		322,509	39	322,548		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,117,928	569,874	2,656,548	5,344,350		5,344,350	(67,827)	5,276,523		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 **FREEPORT MANOR**

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,929)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	39	39		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(723)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(2,048)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,048)	21		24
25	Fund Raising, Advertising and Promotional	(11,368)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(947)	36		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,024)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(23,103)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	18,300	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,803)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (67,827)		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			X		39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

FREEPORT MANORID# 29322Report Period Beginning: 7/1/2003Ending: 6/30/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (199)	21	1
2	Raw Foods Rebate	(748)	2	2
3	0	0	0	3
4	0	0	0	4
5	0	0	0	5
6	0	0	0	6
7	0	0	0	7
8	0	0	0	8
9	0	0	0	9
10	0	0	0	10
11	0	0	0	11
12	0	0	0	12
13	0	0	0	13
14	0	0	0	14
15	0	0	0	15
16	0	0	0	16
17	0	0	0	17
18	0	0	0	18
19	0	0	0	19
20	0	0	0	20
21	0	0	0	21
22	0	0	0	22
23	0	0	0	23
24	0	0	0	24
25	0	0	0	25
26	0	0	0	26
27	0	0	0	27
28	0	0	0	28
29	0	0	0	29
30	0	0	0	30
31	0	0	0	31
32	0	0	0	32
33	0	0	0	33
34	0	0	0	34
35	0	0	0	35
36	0	0	0	36
37	0	0	0	37
38	0	0	0	38
39	0	0	0	39
40	0	0	0	40
41	0	0	0	41
42	0	0	0	42
43	0	0	0	43
44	0	0	0	44
45	0	0	0	45
46	0	0	0	46
47	0	0	0	47
48	0	0	0	48
49	Total	(947)		49

Facility Name & ID Number

FREEPOR MANOR

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		See Attached Listings				

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	5 Heat and Other Utilities	\$	Midamerica Care Foundation	100.00%	\$		1	
2	V	19 Professional Services		Midamerica Care Foundation	100.00%	2,237	2,237	2	
3	V	20 Due, Fees, Subscriptions & Promotions		Midamerica Care Foundation	100.00%	0		3	
4	V	21 Clerical & Other General Office		Midamerica Care Foundation	100.00%	1,035	1,035	4	
5	V	22 Employee Benefits		Midamerica Care Foundation	100.00%	9,157	9,157	5	
6	V	24 Travel & Seminar		Midamerica Care Foundation	100.00%	1,146	1,146	6	
7	V	26 Insurance		Midamerica Care Foundation	100.00%	4,725	4,725	7	
8	V	0	0	0	0.00%			8	
9	V	0	0	0	0.00%			9	
10	V	0	0	0	0.00%			10	
11	V	0	0	0	0.00%			11	
12	V	0	0	0	0.00%			12	
13	V	0	0	0	0.00%			13	
14	Total		\$			\$ 18,300	\$ *	18,300	14

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

Facility Name & ID Number

FREEPORT MANOR

29322

Report Period Beginning: **7/1/2003**

Ending:

6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		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	\$		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 FREEPORT MANOR

29322

Report Period Beginning:

7/1/2003

Ending: 7/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization MidAmerica Care Foundation
 Street Address 7611 State Line Rd Ste 301
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816-444-0900
 Fax Number ()

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.

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	5	eat and Other Utilities	Patient Days	241015	8	\$ 0	\$ 40,371	\$	1
2	19	Professional Services	Patient Days	241015	8	13,353	40,371	2,237	2
3	20	, Subscriptions & Promotions	Patient Days	241015	8	0	40,371		3
4	21	al & Other General Office	Patient Days	241015	8	6,180	40,371	1,035	4
5	22	Employee Benefits	Patient Days	241015	8	54,667	40,371	9,157	5
6	24	Travel & Seminar	Patient Days	241015	8	6,843	40,371	1,146	6
7	26	Insurance	Patient Days	241015	8	28,208	40,371	4,725	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					\$ 109,251	\$	\$ 18,300	25

Facility Name & ID Number

FREEPORT MANOR

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	Freeport Class 6(B) Bonds	X	Mortgage	VARIES	1/1/1985	\$ 3,700,000	3,936,706	12/1/2015	0.135	\$ 427,291	1							
2	Bank of America LOC	X	W/C Constructions	Varies			1,641,220		0.0875	143,607	2							
3	Gold Bank		LOC	Varies			554,413		0.09	49,897	3							
4											4							
5											5							
Working Capital																		
6	Interest Income	X								(723)	6							
7	H/O Interest Income										7							
8											8							
9	TOTAL Facility Related					\$ 3,700,000	\$ 6,132,339			\$ 620,072	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$ 3,700,000	\$ 6,132,339			\$ 620,072	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FREEPORT MANOR COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 29322

CONTACT PERSON REGARDING THIS REPORT Ken Marx, BKD, LLP

TELEPHONE 314-231-5544 FAX #: 314-231-9731

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number FREEPORT MANOR

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,050 B. General Construction Type: Exterior BRICK & BLOCK Frame _____ Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: 632,321 2. Number of Years Over Which it is Being Amortized: Various
 3. Current Period Amortization: 23,103 4. Dates Incurred: Various

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>43,050</u>	<u>1985</u>	<u>\$ 30,182</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	43,050		\$ 30,182	3

Facility Name & ID Number FREEPORT MANOR

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	116	85	71	\$ 2400000	\$ 80,000	30	\$ 80,000	\$	\$ 1,553,333	4
5	27			1283650	43,292	30	43,292		283,551	5
6				74846	2,495	30	2,495		49,900	6
7				5601	187	30	187		3,740	7
8										8
	Improvement Type**									
9	Improvements 1985		85	27,210		30			39,813	9
10	Improvements 1986		86	825	29	28	29		522	10
11	Improvements 1988		88	2,440		20			3,128	11
12	Improvements 1989		89	3,190		5			5,790	12
13	Improvements 1990		90	17,268	851	7	851		17,268	13
14	Improvements 1991		91	32,793		7			32,793	14
15	Improvements 1992		92	627		7			627	15
16	Improvements 1993		93	16,433		7			21,572	16
17	Improvements 1994		94	73,875		10			73,875	17
18	Improvements 1995		95	41,480		25			51,426	18
19	Improvements 1996		96	3,891		20			18,966	19
20	Compressor		98	510	51	10	51		298	20
21	Heater- Wall		98	2,181	145	15	145		799	21
22	Stairwell Gates		98	1,100	73	15	73		476	22
23	WALLGUARD-D.R.		98	2,436	244	10	244		1,503	23
24	BUILDING UPGRADE		98	9,279	309	30	309		1,881	24
25	MULTIZONE PREHEAT COIL		98	13,600	907	15	907		5,063	25
26	LAUNDRY ROOM DRAIN VALVE		99	592	39	15	39		194	26
27	DRAPERIES, 22 PR, VALANCES, RODS		99	5,906	591	10	591		2,707	27
28	WATER COIL-KITCHEN		2000	779	78	10	78		331	28
29	HOT WATER TANK, 100 GAL		2001	3,050	203	15	203		796	29
30	Sign for Main Building		2001	3,975	331	12	331		1,214	30
31										31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **FREEPORT MANOR**

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Light Fixtures (3 qty.)	2001	\$ 663	\$ 66	10	\$ 66	\$	\$ 215	37
38	PARKING LOT RESEALING	2001	8,705	1,741	5	1,741		6,529	38
39	Repave damaged section of parking lot	2001	525	105	5	105		385	39
40	Landscaping	2001	11,248	1,125	10	1,125		3,937	40
41	Flag Pole/Sign Lighting	2001	2,250	150	15	150		450	41
42	Flagpole	2001	969	48	20	48		145	42
43	2 New Nurse Stations	2001	14,220	948	15	948		2,686	43
44	Building Renovation	2002	343,343	17,167	20	17,167		47,210	44
45	Replacement of Sidewalks	2002	6,485	432	15	432		1,189	45
46	Repair Back Dock	2003	4,983	498	10	498		996	46
47	Hot Water Heater	2002	2,797	280	10	280		560	47
48	Hot Water Heater	2003	2,800	280	10	280		280	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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13								13
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20								20
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	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
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17								17
18								18
19								19
20								20
21								21
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23								23
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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14								14
15								15
16								16
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30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
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30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

Facility Name & ID Number **FREEPORT MANOR**

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
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29								29
30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
3								3
4								4
5								5
6								6
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30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
3								3
4								4
5								5
6								6
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30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	1
2								2
3								3
4								4
5								5
6								6
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29								29
30								30
31								31
32								32
33								33
34		\$ 4,426,525	\$ 152,665		\$ 152,665	\$	\$ 2,236,148	34

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

Facility Name & ID Number **FREEPORT MANOR**

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

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	\$ 692,487	\$ 37,910	\$ 37,910	\$		\$ 466,798	71
72	Current Year Purchases	14,537	953	953			953	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 707,024	\$ 38,863	\$ 38,863	\$		\$ 467,751	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		93	93	\$ 20,847	\$	\$	\$	7	\$ 20,847	76
77										77
78										78
79										79
80	TOTALS			\$ 20,847	\$	\$	\$		\$ 20,847	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)	\$ 5,184,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 191,528	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,724,746	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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:	<u>N/A</u>			\$			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: \$ 3,357 Description: See attached detail for rental expense

(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	<u>N/A</u>		\$	\$	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. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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 AIDE _____</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 AIDE _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	2,918	\$ 131,291	\$ 90	2,918	\$ 131,381	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		177	7,979	0	177	7,979	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		4,066	182,972	0	4,066	182,972	4
5	Physician Care	0	visits		0	0	0			5
6	Dental Care	0	visits		0	0	0			6
7	Work Related Program	0	hrs		0	0	0			7
8	Habilitation	0	hrs		0	0	0			8
9	Pharmacy		# of prescripts		0	0	0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs		0	0	0			10
11	Academic Education	0	hrs		0	0	0			11
12	Exceptional Care Program	0			0	0	0			12
13	Other (specify):	0			0	0	0			13
14	TOTAL			\$	7,161	\$ 322,242	\$ 90	7,161	\$ 322,332	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **FREEPORT MANOR**# **29322**Report Period Beginning: **7/1/2003**

Ending:

6/30/2004**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2004**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 277,897	\$	1
2	Cash-Patient Deposits	11,880		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	778,610		3
4	Supply Inventory (priced at)	16,104		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,891		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,089,382	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,329,610		14
15	Leasehold Improvements, at Historical Cost	30,182		15
16	Equipment, at Historical Cost	707,024		16
17	Accumulated Depreciation (book methods)	(2,706,568)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	632,321		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(412,921)		20
21	Restricted Funds	1,837		21
22	Other Long-Term Assets (spe			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,581,485	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,670,867	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 198,078	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,880		28
29	Short-Term Notes Payable	2,195,633		29
30	Accrued Salaries Payable	98,922		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,198		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,742,855		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other accrued expenses	61,073		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,320,639	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,936,706		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)	\$ 3,936,706	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,257,345	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,586,478)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,670,867	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,142,410)	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,142,410)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(444,068)	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)	0	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (444,068)	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)	\$ (7,586,478)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **FREEPORT MANOR**

29322

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

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	\$ 4,544,288	1
2	Discounts and Allowances for all Levels	(708,213)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,836,075	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	697,569	6
7	Oxygen	36,297	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 733,866	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,929	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	287,454	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,260	19
20	Radiology and X-Ray		20
21	Other Medical Services	22,805	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 338,448	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	723	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 723	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	(8,830)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (8,830)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,900,282	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	810,942	31
32	Health Care	2,239,888	32
33	General Administration	1,132,228	33
B. Capital Expense			
34	Ownership	838,783	34
C. Ancillary Expense			
35	Special Cost Centers	244,001	35
36	Provider Participation Fee	78,508	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,344,350	40
41	Income before Income Taxes (line 30 minus line 40)**	(444,068)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (444,068)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Pending 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 **FREEPORT MANOR**

29322

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	7,753	7,893	\$ 281,351	\$ 35.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,327	8,403	197,136	23.46	3
4	Licensed Practical Nurses	19,490	19,654	391,028	19.90	4
5	Nurse Aides & Orderlies	68,128	68,804	682,401	9.92	5
6	Nurse Aide Trainees	4,169	4,225	42,407	10.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,187	4,505	50,483	11.21	10
11	Social Service Workers	6,418	6,490	105,532	16.26	11
12	Dietician	18,898	19,060	184,316	9.67	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,896	1,936	43,327	22.38	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,872	1,912	68,810	35.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,688	5,748	59,293	10.32	23
24	Clerical					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	1,386	1,402	11,844	8.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,212	150,032	\$ 2,117,928 *	\$ 14.12	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	223	\$ 8,799	1, 3	35
36	Medical Director	66	15,600	9, 3	36
37	Medical Records Consultant	16	1,200	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	118	6,399	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	12	591	10a, 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,359	11, 3	44
45	Social Service Consultant	40	2,552	12, 3	45
46	Other(specify)	0			46
47					47
48					48
49	TOTAL (lines 35 - 48)	518	\$ 37,500		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	Nurse 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	
DARLENE HANSEN	Admin.	0	\$ 68,810	Workers' Compensation Insurance	\$ 120,191	IDPH License Fee	\$	
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	4,595	
				FICA Taxes	182,271	Health Care Worker Background Check		
				Employee Health Insurance	57,718	(Indicate # of checks performed _____)		
				Employee Meals	0			
				Illinois Municipal Retirement Fund (IMRF)*	0	Dues & Subscriptions	10,827	
				Other Benefits	5,979	Advertising & Public Relations	11,368	
					0			
					0			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,810	Home Office Allocation	9,157	Home Office Allocation		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 375,317	
Description			Amount				Less: Public Relations Expense (0)	
			\$				Non-allowable advertising (11,368)	
							Yellow page advertising	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			\$ 15,422	
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
Legal Fees	Various	0	\$ 18,007	N/A			Out-of-State Travel	\$
Purchased Service	Various		28,191					
Data Processing	Various		8,623				In-State Travel	7,289
Accounting	Various		9,580					
Professional Services	Various		988				Seminar Expense	0
Management Fees	Various		294,016				Business Meals	
Trustee Expense	Various		4,000				Home Office Allocation	4,725
							Entertainment Expense	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 363,405	TOTAL		\$	TOTAL	\$ 12,014

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. 7722 - Illinois Health Care Assoc.
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,130 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 78,508
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,929
- (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? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BKD, LLP KC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. In progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.