

		FOR OHF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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>0025098</u></p> <p>Facility Name: <u>FREEBURG CARE CENTER</u></p> <p>Address: <u>746 URBANNA DRIVE</u> <u>FREEBURG</u> <u>62243</u> Number City Zip Code</p> <p>County: <u>ST. CLAIR</u></p> <p>Telephone Number: <u>(618)539-5856</u> Fax # <u>(618)539-3412</u></p> <p>IDPA ID Number: <u>371062186001</u></p> <p>Date of Initial License for Current Owners: <u>03/14/79</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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 _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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 _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ROGER BAGLEY</u> Telephone Number: <u>(618)549-8331</u> <u>JAMESTOWN MANAGEMENT</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<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>01/01/2005</u> to <u>12/31/2005</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"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROGER W. BAGLEY</u></td> </tr> <tr> <td></td> <td>(Title) <u>CONTROLLER</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>ROGER W. BAGLEY</u>		(Title) <u>CONTROLLER</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) (____) _____ Fax # (____) _____																																		

Facility Name & ID Number FREEBURG CARE CENTER

0025098 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	899	9,757	1,544	12,200	8
9	SNF/PED					9
10	ICF	16,288	3,571		19,859	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,187	13,328	1,544	32,059	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.43%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 03/16/79

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/16/79 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 1,544

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number **FREEBURG CARE CENTER** # **0025098** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	143,413	9,311	7,688	160,412		160,412		160,412		1
2	Food Purchase		110,529		110,529	4,007	114,536	(811)	113,725		2
3	Housekeeping	91,655	12,763		104,418		104,418		104,418		3
4	Laundry	51,854	9,188		61,042		61,042		61,042		4
5	Heat and Other Utilities			87,836	87,836		87,836		87,836		5
6	Maintenance	43,614	17,996	30,711	92,321		92,321	(723)	91,598		6
7	Other (specify):*										7
8	TOTAL General Services	330,536	159,787	126,235	616,558	4,007	620,565	(1,534)	619,031		8
B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,186,037	28,954	139,074	1,354,065	(4,007)	1,350,058		1,350,058		10
10a	Therapy			62	62		62		62		10a
11	Activities	30,794	4,741	1,200	36,735		36,735	(436)	36,299		11
12	Social Services	26,523		1,200	27,723		27,723		27,723		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,243,354	33,695	144,536	1,421,585	(4,007)	1,417,578	(436)	1,417,142		16
C. General Administration											
17	Administrative	64,338		6,600	70,938		70,938		70,938		17
18	Directors Fees			3,800	3,800		3,800		3,800		18
19	Professional Services			121,007	121,007		121,007		121,007		19
20	Dues, Fees, Subscriptions & Promotions			11,247	11,247		11,247	(2,156)	9,091		20
21	Clerical & General Office Expenses	50,332	9,394	8,200	67,926		67,926	(136)	67,790		21
22	Employee Benefits & Payroll Taxes			327,829	327,829		327,829		327,829		22
23	Inservice Training & Education			85	85		85		85		23
24	Travel and Seminar			3,151	3,151		3,151		3,151		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,579	90,579		90,579		90,579		26
27	Other (specify):*										27
28	TOTAL General Administration	114,670	9,394	572,498	696,562		696,562	(2,292)	694,270		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,688,560	202,876	843,269	2,734,705		2,734,705	(4,262)	2,730,443		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

FREEBURG CARE CENTER

#0025098

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			23,925	23,925		23,925	68,555	92,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,238	17,238		17,238	12,303	29,541			32
33	Real Estate Taxes			37,446	37,446		37,446		37,446			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(132,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			210,609	210,609		210,609	(51,142)	159,467			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,835	74,069	178,904		178,904		178,904			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		104,835	138,674	243,509		243,509		243,509			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,688,560	307,711	1,192,552	3,188,823		3,188,823	(55,404)	3,133,419			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 **FREEBURG CARE CENTER**

0025098

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

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				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	31,773	30		9
10	Interest and Other Investment Income	(806)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(811)	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	(136)	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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,131)	20		28
29	Other-Attach Schedule	(16,590)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 11,299		\$	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			33
34	Adjustments for Related Organization Costs (Schedule VII)	(66,703)	SCHVII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (66,703)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (55,404)		37

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

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

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

FREEBURG CARE CENTER

ID# 0025098
 Report Period Beginning: 01/01/2005
 Ending: 12/31/2005

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	LINE 29 DETAIL OF OTHER ADJUSTMENTS	\$		1
2				2
3	CHAMBER OF COMMERCE DUES	(25)	20	3
4	ADJUSTMENT FOR DEFERRED PAINT XIX-H	(723)	6	4
5	INTEREST PAID TO OWNERS ON LOAN	(15,406)	32	5
6	ELIMINATE ACTIVITY AND CONTRIBUTION	(436)	11	6
7	EXPENSE PER INCOME RECEIVED			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	(16,590)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER

0025098 Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(811)	0	0	0	0	0	0	0	0	0	0	(811)	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	(723)	0	0	0	0	0	0	0	0	0	0	(723)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,534)	0	0	0	0	0	0	0	0	0	0	(1,534)	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	(436)	0	0	0	0	0	0	0	0	0	0	(436)	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	(436)	0	0	0	0	0	0	0	0	0	0	(436)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,156)	0	0	0	0	0	0	0	0	0	0	(2,156)	20
21	Clerical & General Office Expenses	(136)	0	0	0	0	0	0	0	0	0	0	(136)	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	(2,292)	0	0	0	0	0	0	0	0	0	0	(2,292)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,262)	0	0	0	0	0	0	0	0	0	0	(4,262)	29

Facility Name & ID Number **FREEBURG CARE CENTER**

0025098

Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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
SEE OWNER'S LIST ATTACHED				ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
				LAND TRUST		RENTAL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 132,000	ST. CLAIR ESTATES	100.00%	\$	(132,000)	1
2	V	32 INTEREST EXPENSE		ST. CLAIR ESTATES	100.00%	30,183	30,183	2
3	V	30 DEPRECIATION		ST. CLAIR ESTATES	100.00%	36,782	36,782	3
4	V	32 INTEREST INCOME		ST. CLAIR ESTATES	100.00%	(1,668)	(1,668)	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		\$ 132,000			\$ 65,297	\$ * (66,703)	14

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	LARRY RHUTASEL	CONSULTANT	ADM. CONSUL	6.90	NONE	2	5.00	ADM CONS	\$ 5,400	17/3	1
2	JOHN SCHAUFLE	CONSULTANT	ADM. CONSUL	20.70	NONE	2	5.00	ADM CONS	1,200	17/3	2
3	CAROLYN STUMPF	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fee	800	18/3	3
4	JOHN SCHAUFLE	DIRECTOR	board member	20.70	NONE	N/A	N/A	director fee	800	18/3	4
5	LARRY RHUTASEL	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fee	800	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	board member	3.44	NONE	N/A	N/A	director fee	800	18/3	6
7	WAYNE HEBERER	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fee	600	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,400		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 **FREEBURG CARE CENTER** # **0025098** Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	REGIONS BANK		X	REAL ESTATE MORTGAGE		08/28/97	\$ 1,050,307	\$	08/28/05	0.0375	\$ 19,645	1								
2	CITIZENS COMMUNITY BANK		X	REAL ESTATE MORTGAGE	\$11,000.00	09/07/05	515,000	488,484	09/28/10	VARIABLE	10,538	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LOAN FROM ST. CLAIR	X		OPERATIONS	N/A	N/A	83,000		NONE	variable	1,640	6								
7	REGIONS BANK		X	OPERATIONS	N/A	N/A	30,000		NONE	variable	192	7								
8												8								
9	TOTAL Facility Related				\$11,000.00		\$ 1,678,307	\$ 488,484			\$ 32,015	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,678,307	\$ 488,484			\$ 32,015	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 **FREEBURG CARE CENTER**# **0025098** Report Period Beginning: **01/01/2005** Ending: **12/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2004 report.			\$	40,550	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.)			\$	38,996	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(1,554)	3
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	39,000	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.			\$	37,446	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2000	36,906	8		
		2001	39,594	9		
		2002	38,345	10		
		2003	40,552	11		
		2004	38,996	12		
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2004	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FREEBURG CARE CENTER COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0025098

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 2004 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 2004.

(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>14-29.0-400-040</u>	<u>LOT/SEC-29-SUBL/TWP-1S-BLK</u>	\$ <u>38,970.24</u>	\$ <u>38,970.24</u>
2. <u>14-29.0-400-038</u>	<u>LOT/SEC-29-SUBL/TWP-1S-BLK</u>	\$ <u>25.42</u>	\$ <u>25.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,995.66</u>	\$ <u>38,995.66</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,405 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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

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

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

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

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>150,000</u>	<u>1979</u>	<u>\$ 22,480</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	150,000		\$ 22,480	3

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	98	1979	1979	\$ 1,174,206	\$	30	\$ 39,140	\$ 39,140	\$ 1,048,626	4
5	10	1985	1985	227,899		30	7,597	7,597	155,738	5
6		1985	1986	3,116		30	104	104	2,028	6
7		1989	1989	2,110		27	78	78	1,326	7
8	10	1998	1997	411,348		39.5	10,415	10,415	88,476	8
Improvement Type**										
9	PARKING LOT TITLE INSURANCE		1981	7,109		30	237	237	5,905	9
10	SIDEWALK		1983	908		20			908	10
11	LAUNDRY RENOVATION		1983	3,303		25	132	132	2,970	11
12	STORAGE BUILDING		1983	6,690		20			6,690	12
13	WINDOW REPLACEMENT		1983	967		30	32	32	720	13
14	KITCHEN RENOVATIONS		1983	734		25	29	29	653	14
15	VENTILATION SYSTEM/INSULATION		1984	1,132		10			1,132	15
16	CONCRETE PAVING		1985	4,124		20	107	107	4,124	16
17	PARKING LOT		1986	2,518		10			2,518	17
18	STORAGE SHED		1987	10,213		15			10,213	18
19	DRIVEWAY		1988	3,990		15			3,990	19
20	DRIVEWAY		1989	1,465		15			1,465	20
21	ENTRY SIGN		1990	2,890	92	15	92		2,890	21
22	PARKING LOT		1990	11,951	395	20	598	203	9,269	22
23	SEWER		1990	17,548	573	25	702	129	10,881	23
24	LIGHTS		1990	1,140	38	10		(38)	1,140	24
25	HEAT PUMPS/ COMPRESSOR		1990	2,527	91	8		(91)	2,527	25
26	SEWER REPAIRS/ DRIVEWAY REPAIRS / PLUMBING		1991	4,471	298	15	298		4,322	26
27	ROOFTOP AIR CONDITIONER		1991	4,600		8			4,600	27
28	FRONT OFFICE REMODELING / DRIVEWAY REPAIRS		1992	10,838	723	15	723		9,761	28
29	CARPET		1992	14,036		5			14,036	29
30	PARKING LOT & DRIVEWAY		1993	14,900	993	15	993		12,413	30
31	FENCE / PARKING LOT & DRIVEWAY		1994	6,672	445	15	445		5,118	31
32	CEILING TILE		1994	1,310		5			1,310	32
33	LANDSCAPING		1996	1,499	150	10	150		1,425	33
34	WATER HEATER		1996	3,426	228	15	228		2,166	34
35	5 TON CONDENSING UNIT		1996	1,195	120	10	120		1,140	35
36	WATER LINE & GAS LINE FOR ADDITION		1997	633	63	10	63		536	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 FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	AIR COMPRESSOR FOR FIRE SYSTEM	1997	\$ 1,244	\$ 83	10	\$ 124	\$ 41	\$ 1,054	37
38	CERAMIC TILE & LABOR FOR SHOWERS	1997	5,795	386	10	386		3,281	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	285	5	285		2,422	40
41	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM	1997	503	50	15	50		425	41
42	TELEPHONE SYSTEM	1997	4,640		10	464	464	3,944	42
43	8 G E HEAT / COOL UNITS	1997	7,624		10	762	762	6,477	43
44	cabinets, countertops, & labor for new nurses station and gutting old	1998	6,073	405	15	405		3,037	44
45	expanded care plan office adding countertop & windows	1998	6,952	463	15	463		3,473	46
47	FIRE ALARM	1998	4,431	295	15	295		2,213	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		1,462	48
49	PHONE JACKS INSTALLED	1998	777	52	15	52		390	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10	388	388	2,910	50
51	replaced ceiling tile & constructed new storage cabinets in activity room	1999	4,951	495	10	495		3,218	51
52	ROOF TOP FAN	1999	866	58	15	58		377	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		1,469	54
55	NEW ROOF ON WINGS A,B,&C	1999	16,397		10	1,640	1,640	10,660	55
56	WALLPAPER IN DINING ROOM	2000	1,255	125	5	125		1,255	56
57	guttled bathroom installed windows & worktop to convert to DON office	2000	2,374	237	10	237		1,304	57
58	finish DON office-mudd, sand, and paint room, Set cabinets & build shelves, Put carpet & cove base down & handrail up	2001	2,194	219	10	219		986	59
59	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		526	61
60	remove old shower on d-hall and put in new shower walls and mudd, sand, and paint to seal plaster around shower	2001	2,097	210	10	210		945	62
61	tear out wall between secretary and bookkeeper office and build countertops and workspace, new carpet, paint etc.	2003	6,638	664	10	664		1,660	64
62	BUILD UP ROOF SECTION	2004	8,072	807	10	807		1,211	66
63	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	3,319	3,319	3,319	67
64	firewall laundry room,fire ducts & ceiling tiles in oxygen room	2005	7,588	379	10	379		379	68
65	replace smoke detectors	2005	4,457	223	10	223		223	69
66	TOTAL (lines 4 thru 69)		\$ 2,139,270	\$ 10,183		\$ 74,871	\$ 64,688	\$ 1,480,138	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 158,331	\$ 4,152	\$ 16,667	\$ 12,515	various	\$ 107,243	71
72	Current Year Purchases	9,590	9,590	942	(8,648)	various	942	72
73	Fully Depreciated Assets	350,698				various	350,698	73
74								74
75	TOTALS	\$ 518,619	\$ 13,742	\$ 17,609	\$ 3,867		\$ 458,883	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12L, if applicable)	\$ 2,680,369	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 23,925	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 92,480	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$ 68,555	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 1,939,021	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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: \$ NONE Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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>we only hire trained aides</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39/3	hrs	\$	367	\$ 23,397						367	\$ 23,397	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		80	7,426						80	7,426	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39/3;39/2	hrs		566	36,802			308			566	37,110	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39/2	# of prescripts						82,671				82,671	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	oxygen,tubefeeding, med supplies,iv's Other (specify): lab, x-ray	39/2 39/3				6,444			21,856				28,300	13
14	TOTAL			\$	1,013	\$ 74,069			\$ 104,835			1,013	\$ 178,904	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.

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	\$ 114,084	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	473,074	3
4	Supply Inventory (priced at cost)	3,055	4
5	Short-Term Investments	36,898	5
6	Prepaid Insurance	8,621	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)	\$ 635,732	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cost	192,254	15
16	Equipment, at Historical Cost	351,174	16
17	Accumulated Depreciation (book methods)	(480,847)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 62,581	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 698,313	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 68,458	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	290,000	29
30	Accrued Salaries Payable	38,616	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,478	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,000	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	401K LIABILITY	9,686	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 467,238	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 467,238	46
47	TOTAL EQUITY (page 18, line 24)	\$ 231,075	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 698,313	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 153,080	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 153,080	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	135,995	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	(58,000)	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)	\$ 77,995	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)	\$ 231,075	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	\$ 3,104,548	1
2	Discounts and Allowances for all Levels	66,817	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,171,365	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,948	6
7	Oxygen	15,318	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 146,266	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	4,381	19
20	Radiology and X-Ray	2,000	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,381	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	806	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 806	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)	\$ 3,324,818	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	616,558	31
32	Health Care	1,421,585	32
33	General Administration	696,562	33
B. Capital Expense			
34	Ownership	210,609	34
C. Ancillary Expense			
35	Special Cost Centers	178,904	35
36	Provider Participation Fee	64,605	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,188,823	40
41	Income before Income Taxes (line 30 minus line 40)**	135,995	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 135,995	43

* 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. **Il repl tax deducted on fed tax return**

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

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

Facility Name & ID Number **FREEBURG CARE CENTER**# **0025098**Report Period Beginning: **01/01/2005**Ending: **12/31/2005**

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	3,057	3,380	\$ 73,805	\$ 21.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,474	2,665	51,468	19.31	3
4	Licensed Practical Nurses	21,563	22,374	371,038	16.58	4
5	CNAs & Orderlies	56,133	60,727	665,482	10.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,678	2,987	30,794	10.31	9
10	Activity Assistants					10
11	Social Service Workers	2,013	2,241	26,523	11.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,020	2,204	28,587	12.97	14
15	Cook Helpers/Assistants	13,259	13,995	114,826	8.20	15
16	Dishwashers					16
17	Maintenance Workers	3,058	3,466	43,614	12.58	17
18	Housekeepers	10,446	11,230	91,655	8.16	18
19	Laundry	5,843	6,282	51,854	8.25	19
20	Administrator	1,920	2,080	64,338	30.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,704	4,146	50,332	12.14	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) <u>WARD CLERK</u>	1,988	2,092	24,244	11.59	33
34	TOTAL (lines 1 - 33)	130,156	139,869	\$ 1,688,560 *	\$ 12.07	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	140	\$ 7,688	1/3	35
36	Medical Director		3,000	9/3	36
37	Medical Records Consultant	12	480	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	825	10/3	39
40	Physical Therapy Consultant	1	62	10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	1,200	11/3	44
45	Social Service Consultant	42	1,200	12/3	45
46	Other(specify) <u>ADMINISTRATIVE</u>		6,600	17/3	46
47	<u>TAX SERVICE CONS.</u>		1,000	19/3	47
48	<u>PURCHASING CONS.</u>		16	19/3	48
49	TOTAL (lines 35 - 48)	273	\$ 22,071		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	32	\$ 1,272	10/3	50
51	Licensed Practical Nurses	1,759	50,899	10/3	51
52	Certified Nurse Assistants/Aides	4,740	85,598	10/3	52
53	TOTAL (lines 50 - 52)	6,531	\$ 137,769		53

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	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING	2002	\$ 2,141	3	\$ 357	\$ 714	\$ 714	\$ 356	\$	\$	\$	\$
2	PAINTING	2003	1,616	3		269	539	539	269			
3	PAINTING	2005	1,942	3				324	647	647	324	
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 5,699		\$ 357	\$ 983	\$ 1,253	\$ 1,219	\$ 916	\$ 647	\$ 324	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5.6 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 64,605
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. \$ NONE Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, 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.

FREEBURG CARE CENTER
SCHEDULE OF RECLASSIFICATIONS PAGES 3&4 COLUMN 5
12/31/2005
ID # 0025098

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	4007	
10	NURSING & MEDICAL RECORDS RECL FOOD SUPPLEMENTS		4007