

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

I. IDPH License ID Number: 0029322

Facility Name: FREEPORT REHAB & HEALTH CARE CTR

Address: 900 SOUTH KIWANIS DRIVE FREEPORT 61032
 Number City Zip Code

County: STEPHENSON

Telephone Number: (815-235-6196 Fax # (815-235-5365)

HFS ID Number: 51-0271905

Date of Initial License for Current Owners: 01/01/85

Type of Ownership:

<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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Ken Marx, BKD, LLP **Telephone Number:** (314-231-5544)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2006 to 6/30/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Junior Foster, THSCLLC, Mgmt. Co</u>	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR

0029322 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

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	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,634	9,707	4,268	34,609	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,634	9,707	4,268	34,609	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.72%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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 / 11/1/85 /

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

YES Date 11/1/85 NO

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

YES NO If YES, enter number of beds certified 122 and days of care provided 4,268

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number **FREEPORT REHAB & HEALTH CARE CT** # **0029322** Report Period Beginning: **7/1/2006** Ending: **6/30/2007**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,836	16,425	8,404	220,665		220,665	(5,730)	214,935		1
2	Food Purchase		164,979		164,979		164,979	(660)	164,319		2
3	Housekeeping		27,293	111,536	138,829		138,829		138,829		3
4	Laundry		10,818	74,357	85,175		85,175		85,175		4
5	Heat and Other Utilities			124,315	124,315		124,315	(22,349)	101,966		5
6	Maintenance	46,734	10,773	43,875	101,382		101,382		101,382		6
7	Other (specify):*			5,369	5,369		5,369		5,369		7
8	TOTAL General Services	242,570	230,288	367,856	840,714		840,714	(28,739)	811,975		8
	B. Health Care and Programs										
9	Medical Director			18,650	18,650		18,650		18,650		9
10	Nursing and Medical Records	1,565,664	113,866	8,259	1,687,789		1,687,789		1,687,789		10
10a	Therapy		2,164	261,871	264,035		264,035		264,035		10a
11	Activities	60,666	1,343	4,897	66,906		66,906		66,906		11
12	Social Services	106,663		2,949	109,612		109,612		109,612		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,732,993	117,373	296,626	2,146,992		2,146,992		2,146,992		16
	C. General Administration										
17	Administrative	81,422	(2,781)		78,641		78,641		78,641		17
18	Directors Fees										18
19	Professional Services			378,426	378,426		378,426	9,573	387,999		19
20	Dues, Fees, Subscriptions & Promotions			35,185	35,185		35,185	(14,230)	20,955		20
21	Clerical & General Office Expenses	91,362	28,294	170,917	290,573		290,573	(96,572)	194,001		21
22	Employee Benefits & Payroll Taxes			377,771	377,771		377,771	11,773	389,544		22
23	Inservice Training & Education			137	137		137		137		23
24	Travel and Seminar			5,884	5,884		5,884	941	6,825		24
25	Other Admin. Staff Transportation			6,061	6,061		6,061		6,061		25
26	Insurance-Prop.Liab.Malpractice			151,256	151,256		151,256	6,923	158,179		26
27	Other (specify):*										27
28	TOTAL General Administration	172,784	25,513	1,125,637	1,323,934		1,323,934	(81,592)	1,242,342		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,148,347	373,174	1,790,119	4,311,640		4,311,640	(110,331)	4,201,309		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 FREEPORT REHAB & HEALTH CARE CTR #0029322 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			192,660	192,660		192,660		192,660		30
31	Amortization of Pre-Op. & Org.			20,305	20,305		20,305	(20,305)			31
32	Interest			664,183	664,183		664,183	(3,236)	660,947		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			1,332	1,332		1,332		1,332		35
36	Other (specify):*										36
37	TOTAL Ownership			878,480	878,480		878,480	(23,541)	854,939		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		198,601	60,316	258,917		258,917	382	259,299		39
40	Barber and Beauty Shops			846	846		846		846		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			78,294	78,294		78,294		78,294		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		198,601	139,456	338,057		338,057	382	338,439		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,148,347	571,775	2,808,055	5,528,177		5,528,177	(133,490)	5,394,687		45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(5,730)	1		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	382	39		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,236)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(660)	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	(6,208)	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	(95,905)	21		24
25	Fund Raising, Advertising and Promotional	(14,230)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	4,987	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,600)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(20,305)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	7,415		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,890)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (133,490)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
FREEPORT REHAB & HEALTH CARE CTR

ID# 0029322
 Report Period Beginning: 7/1/2006
 Ending: 6/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	MISSCELLANEOUS INCOME	\$ 4,987	21
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	4,987	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR

0029322

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

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	(5,730)	0	0	0	0	0	0	0	0	0	0	(5,730)	1
2	Food Purchase	(660)	0	0	0	0	0	0	0	0	0	0	(660)	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	(22,349)	0	0	0	0	0	0	0	0	0	(22,349)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,390)	(22,349)	0	(28,739)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,573	0	0	0	0	0	0	0	0	0	9,573	19
20	Fees, Subscriptions & Promotions	(14,230)	0	0	0	0	0	0	0	0	0	0	(14,230)	20
21	Clerical & General Office Expenses	(97,126)	554	0	0	0	0	0	0	0	0	0	(96,572)	21
22	Employee Benefits & Payroll Taxes	0	11,773	0	0	0	0	0	0	0	0	0	11,773	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	941	0	0	0	0	0	0	0	0	0	941	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	6,923	0	0	0	0	0	0	0	0	0	6,923	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(111,356)	29,764	0	(81,592)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,746)	7,415	0	(110,331)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR

0029322

Report Period Beginning:

7/1/2006 Ending:

6/30/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(20,305)	0	0	0	0	0	0	0	0	0	0	(20,305)	31
32	Interest	(3,236)	0	0	0	0	0	0	0	0	0	0	(3,236)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,541)	0	0	0	0	0	0	0	0	0	0	(23,541)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	382	0	0	0	0	0	0	0	0	0	0	382	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	382	0	0	0	0	0	0	0	0	0	0	382	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(140,905)	7,415	0	(133,490)	45								

Facility Name & ID Number FREEMPORT REHAB & HEALTH CARE CTR

0029322

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

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	\$ 22,349	Mid America Care Foundation	100.00%	\$	\$ (22,349)	1
2	V	19 Professional Services		Mid America Care Foundation	100.00%	9,573	9,573	2
3	V	20 Dues, Fees, Sunscriptions & Promotions		Mid America Care Foundation	100.00%			3
4	V	21 Clerical & Other Gen. Office		Mid America Care Foundation	100.00%	554	554	4
5	V	22 Employee Benefits		Mid America Care Foundation	100.00%	11,773	11,773	5
6	V	24 Travel & Seminar		Mid America Care Foundation	100.00%	941	941	6
7	V	26 Insurance		Mid America Care Foundation	100.00%	6,923	6,923	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 22,349			\$ 29,764	\$ * 7,415	14

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

Facility Name & ID Number FREEMONT REHAB & HEALTH CARE C # 0029322 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

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									\$	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 REHAB & HEALTH CARE CTR # 0029322 Report Period Beginning: 7/1/2006 Ending: 7/30/2007

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 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 ()

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	Heat and Other Utilities	PATIENT DAYS	146,980	5	\$	34,609	\$ 0	1
2	19	Professional Services	PATIENT DAYS	146,980	5	40,655	34,609	9,573	2
3	20	Dues, Fees, Sunscriptions & Prom	PATIENT DAYS	146,980	5		34,609	0	3
4	21	Clerical & Other Gen. Office	PATIENT DAYS	146,980	5	2,354	34,609	554	4
5	22	Employee Benefits	PATIENT DAYS	146,980	5	50,000	34,609	11,773	5
6	24	Travel & Seminar	PATIENT DAYS	146,980	5	3,996	34,609	941	6
7	26	Insurance	PATIENT DAYS	146,980	5	29,400	34,609	6,923	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					\$ 126,405	\$	\$ 29,764	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	Freeport Class 6(B) Bonds		X	Mortgage	Varies	1/1/85	\$ 3,700,000	\$ 3,936,706	12/1/2015	0.1350	\$ 523,559	1								
2	Bonds Repurchased							(18,438)				2								
3	Bank of America LOC		X	W/C Construction	Varies			1,079,067			140,624	3								
4	Gold Bank		X	LOC	Varies			494,413		0.0875		4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 3,700,000	\$ 5,491,748			\$ 664,183	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	\$ 5,491,748			\$ 664,183	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FREEPORT REHAB & HEALTH CARE CTR COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0029322

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 2006 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 2006.

(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.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR

0029322 Report Period Beginning:

7/1/2006 Ending:

6/30/2007

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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: 20,721 4. Dates Incurred: Various

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>Facility</u>	<u>43,050</u>		\$	1
2					2
3	TOTALS	43,050		\$	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	122		85	71	\$ 2,400,000	\$ 80,000	30	\$ 80,000		\$ 1,793,333	4
5				85	77,323	2,578	30	2,578		57,774	5
6				95	91,858	2,184	Various	2,184		30,101	6
7				96	54,362	1,591	Various	1,591		17,591	7
8					1,470,320	60,018	Various	60,018		510,542	8
	Improvement Type**										
9	Improvements 1985			1985	(80,268)	(2,665)	Various	(2,665)		(60,045)	9
10	Improvements 1986			1986	825	28	Various	28		612	10
11	Improvements 1988			1988	2,440	122	Various	122		2,296	11
12	Improvements 1989			1989	3,190		Various			3,190	12
13	Improvements 1990			1990	13,950		Various			13,950	13
14	Improvements 1991			1991	32,793		Various			32,789	14
15	Improvements 1992			1992	627		Various			627	15
16	Improvements 1993			1993	17,273		Various			17,273	16
17	Improvements 1994			1994	67,523		Various			67,240	17
18	Improvements 1995			1995	57,948	902	Various	902		42,623	18
19	Improvements 1996			1996	13,187	599	Various	599		10,664	19
20	Improvements 1997			1997	33,561	1,885	Various	1,885		26,108	20
21	Improvements 1998			1998	18,623	1,283	Various	1,283		11,233	21
22	Improvements 1999			1999	20,807	1,584	Various	1,584		12,321	22
23	Improvements 2000			2000	17,034	612	Various	612		13,410	23
24	Improvements 2001			2001	35,835	2,770	Various	2,770		16,932	24
25	Improvements 2002			2002	7,781	778	Various	778		3,732	25
26	Water Heater			2003	2,800	280	10	280		1,120	26
27	Install Wall With Fire Doors			2004	2,172	217	10	217		633	27
28	Front Doors			2006	13,678	1,368	10	1,368		2,052	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **FREEPORT REHAB & HEALTH CARE CTR**

0029322

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

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	
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								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								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		4,375,642	156,134		156,134		2,628,101	

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

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR # 0029322 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

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	\$ 765,759	\$ 36,188	\$ 36,188	\$	Various	\$ 654,518	71
72	Current Year Purchases	11,990	338	338		Various	338	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 777,749	\$ 36,526	\$ 36,526	\$		\$ 654,856	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,153,391	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 192,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 192,660	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)	\$ 3,282,957	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 1,332 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.

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR # 0029322 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	1,953	\$ 125,018	\$	1,953	\$ 125,018	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		102	6,539		102	6,539	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,036	130,314		2,036	130,314	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	4,091	\$ 261,871	\$	4,091	\$ 261,871	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **FREEMPORT REHAB & HEALTH CARE CTR**# **0029322**Report Period Beginning: **7/1/2006**

Ending:

6/30/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2007**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 57,143	\$	1
2	Cash-Patient Deposits	15,363		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	630,400		3
4	Supply Inventory (priced at)	16,951		4
5	Short-Term Investments	40,107		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,708		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 763,672	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,347,310		14
15	Leasehold Improvements, at Historical Cost	30,182		15
16	Equipment, at Historical Cost	779,660		16
17	Accumulated Depreciation (book methods)	(3,282,957)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	632,321		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(475,661)		20
21	Restricted Funds	1,837		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,032,692	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,796,364	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 325,335	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,363		28
29	Short-Term Notes Payable	494,413		29
30	Accrued Salaries Payable	96,051		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,833		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	6,276,909		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,253,904	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,997,334		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)	\$ 4,997,334	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,251,238	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,454,874)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,796,364	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,670,031)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,670,031)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(784,843)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (784,843)	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)	\$ (9,454,874)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FREEPORT REHAB & HEALTH CARE CTR # 0029322 Report Period Beginning: 7/1/2006Ending: 6/30/2007**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	\$ 4,754,297	1
2	Discounts and Allowances for all Levels	(978,688)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,775,609	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	532,887	6
7	Oxygen	16,835	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 549,722	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	5,731	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	323,589	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,439	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,377	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 420,136	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,236	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,236	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	(5,369)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (5,369)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,743,334	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	840,714	31
32	Health Care	2,146,992	32
33	General Administration	1,323,934	33
B. Capital Expense			
34	Ownership	878,480	34
C. Ancillary Expense			
35	Special Cost Centers	259,763	35
36	Provider Participation Fee	78,294	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,528,177	40
41	Income before Income Taxes (line 30 minus line 40)**	(784,843)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (784,843)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **FREEMONT REHAB & HEALTH CARE CTR**

0029322

Report Period Beginning: **7/1/2006**

Ending:

6/30/2007

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	9,693	10,667	\$ 226,107	\$ 21.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,952	4,082	81,079	19.86	3
4	Licensed Practical Nurses	27,624	29,701	527,704	17.77	4
5	CNAs & Orderlies	61,056	65,592	680,790	10.38	5
6	CNA Trainees	3,555	3,861	40,110	10.39	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,575	4,929	60,666	12.31	10
11	Social Service Workers	6,445	7,116	106,663	14.99	11
12	Dietician	19,065	20,416	195,836	9.59	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,940	2,176	46,734	21.48	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,952	2,080	88,367	42.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,012	6,574	83,575	12.71	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	1,139	1,347	10,716	7.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,008	158,541	\$ 2,148,347 *	\$ 13.55	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	213	\$ 8,404	1,3	35
36	Medical Director	79	18,650	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	3,091	11,3	44
45	Social Service Consultant	46	2,949	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	394	\$ 33,094		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DARLENE HANSEN	ADMIN	0	\$ 81,442	Workers' Compensation Insurance	\$ 125,131	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	12,430	
				FICA Taxes	170,687	Health Care Worker Background Check		
				Employee Health Insurance	57,521	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	274	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,251	
				Qualified/ Non Qualified Pension	4,764	Advertising & Public Relations	14,230	
				Other Benefits	19,667			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 81,442	Home Office	11,773	Less: Public Relations Expense	(14,230)	
(List each licensed administrator separately.)						Non-allowable advertising	()	
B. Administrative - Other						Yellow page advertising	()	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
			\$		\$ 389,543		\$ 20,955	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
							Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Out-of-State Travel	\$
(Attach a copy of any management service agreement)								
C. Professional Services							In-State Travel	5,884
Vendor/Payee	Type		Amount				Seminar Expense	
See Attached	Purchased Services		\$ 35,625				Home Office	941
Tutera Management	Management Fees		284,244				Entertainment Expense	()
Michael F Flanagan LLC	Legal Fees		24,176				(agree to Sch. V, line 24, col. 8)	
BKD, LLP	Accounting Fees		14,305				TOTAL	\$ 6,825
Galaxy Hosted Software	Data Processing Fees		15,115					
Pinnacle Consulting	Professional Services		720					
US Bank	Trustee Expenses		4,240					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 378,425	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* 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. 8551-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? _____
- (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) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,785 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? NL
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 during this cost report period. \$ 78,294
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. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 5,730
- (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? 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? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.