

Facility Name & ID Number FREEBURG CARE CENTER# 0025098 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>34,038</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>25</u>	Intermediate (ICF)	<u>25</u>	<u>9,150</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,188</u>	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		<u>12,926</u>	<u>1,423</u>	<u>14,349</u>	8
9	SNF/PED					9
10	ICF	<u>13,578</u>	<u>3,304</u>		<u>16,882</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,578</u>	<u>16,230</u>	<u>1,423</u>	<u>31,231</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.31%

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)

NONEF. 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 1,423Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: _____

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

Facility Name & ID Number **FREEBURG CARE CENTER** # **0025098** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	146,081	7,937	8,107	162,125		162,125		162,125		1
2	Food Purchase		131,873		131,873	4,269	136,142	(1,258)	134,884		2
3	Housekeeping	95,962	16,313		112,275		112,275		112,275		3
4	Laundry	58,559	9,768		68,327		68,327		68,327		4
5	Heat and Other Utilities			102,421	102,421		102,421		102,421		5
6	Maintenance	51,229	20,694	36,587	108,510		108,510	324	108,834		6
7	Other (specify):*										7
8	TOTAL General Services	351,831	186,585	147,115	685,531	4,269	689,800	(934)	688,866		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,148,487	33,978	352,647	1,535,112	(4,269)	1,530,843		1,530,843		10
10a	Therapy			996	996		996		996		10a
11	Activities	35,667	3,500	1,583	40,750		40,750		40,750		11
12	Social Services	29,131		1,583	30,714		30,714		30,714		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,213,285	37,478	359,809	1,610,572	(4,269)	1,606,303		1,606,303		16
	C. General Administration										
17	Administrative	72,636		8,200	80,836		80,836		80,836		17
18	Directors Fees			2,800	2,800		2,800		2,800		18
19	Professional Services			129,604	129,604		129,604		129,604		19
20	Dues, Fees, Subscriptions & Promotions			13,863	13,863		13,863	(2,688)	11,175		20
21	Clerical & General Office Expenses	56,102	10,827	8,892	75,821		75,821	(503)	75,318		21
22	Employee Benefits & Payroll Taxes			230,517	230,517		230,517		230,517		22
23	Inservice Training & Education			173	173		173		173		23
24	Travel and Seminar			3,399	3,399		3,399		3,399		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,987	58,987		58,987		58,987		26
27	Other (specify):*										27
28	TOTAL General Administration	128,738	10,827	456,435	596,000		596,000	(3,191)	592,809		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,693,854	234,890	963,359	2,892,103		2,892,103	(4,125)	2,887,978		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: 01/01/2008 Ending: 12/31/2008

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			24,757	24,757	24,757	70,747	95,504			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,574	19,574	19,574	(14,221)	5,353			32
33	Real Estate Taxes			36,880	36,880	36,880		36,880			33
34	Rent-Facility & Grounds			144,000	144,000	144,000	(144,000)				34
35	Rent-Equipment & Vehicles			28	28	28		28			35
36	Other (specify):*										36
37	TOTAL Ownership			225,239	225,239	225,239	(87,474)	137,765			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		77,102	89,506	166,608	166,608		166,608			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			64,782	64,782	64,782		64,782			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		77,102	154,288	231,390	231,390		231,390			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,693,854	311,992	1,342,886	3,348,732	3,348,732	(91,599)	3,257,133			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: **01/01/2008**

Ending: **12/31/2008**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,125	30		9
10	Interest and Other Investment Income	(6,109)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,258)	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	(228)	21		18
19	Entertainment				19
20	Contributions	(275)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,663)	20		28
29	Other-Attach Schedule	(19,275)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (683)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(90,916)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (90,916)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (91,599)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

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	ADJUSTEMENT FOR DEFERRED PAINT XIX-H	324	6	4
5	INTEREST PAID TO OWNERS ON LOAN	(19,574)	32	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	(19,275)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,258)	0	0	0	0	0	0	0	0	0	0	(1,258)	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	324	0	0	0	0	0	0	0	0	0	0	324	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(934)	0	0	0	0	0	0	0	0	0	0	(934)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,688)	0	0	0	0	0	0	0	0	0	0	(2,688)	20
21	Clerical & General Office Expenses	(503)	0	0	0	0	0	0	0	0	0	0	(503)	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	(3,191)	0	0	0	0	0	0	0	0	0	0	(3,191)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,125)	0	0	0	0	0	0	0	0	0	0	(4,125)	29

STATE OF ILLINOIS

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

0025098

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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	29,125	41,622	0	0	0	0	0	0	0	0	0	70,747	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,683)	11,462	0	0	0	0	0	0	0	0	0	(14,221)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(144,000)	0	0	0	0	0	0	0	0	0	(144,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,442	(90,916)	0	(87,474)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(683)	(90,916)	0	(91,599)	45								

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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: 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	34 RENT	\$ 144,000	ST. CLAIR ESTATES	100.00%	\$	\$ (144,000)	1
2	V	32 INTEREST EXPENSE		ST. CLAIR ESTATES	100.00%	11,962	11,962	2
3	V	30 DEPRECIATION		ST. CLAIR ESTATES	100.00%	41,622	41,622	3
4	V	32 INTEREST INCOME		ST. CLAIR ESTATES	100.00%	(500)	(500)	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		\$ 144,000			\$ 53,084	\$ * (90,916)	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: 01/01/2008 Ending: 12/31/2008

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	2,800	17/3	2
3	DALE TOWERS	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	600	18/3	3
4	JOHN SCHAUFLE	DIRECTOR	board member	20.70	NONE	N/A	N/A	director fees	600	18/3	4
5	LARRY RHUTASEL	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	600	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	board member	3.44	NONE	N/A	N/A	director fees	600	18/3	6
7	CAROLYN STUMPF	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	400	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,000		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: 01/01/2008 Ending: 2/31/2008

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

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	CITIZENS COMMUNITY BANK	X	REAL ESTATE MORTGAGE	\$11,000.00	09/07/05	\$ 515,000	\$ 163,259	09/28/10	variable	\$ 11,962	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related			\$11,000.00		\$ 515,000	\$ 163,259			\$ 11,962	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 515,000	\$ 163,259			\$ 11,962	15									

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2007 report.		\$ 39,000	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.)		\$ 36,880	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,120)	3																																	
4. Real Estate Tax accrual used for 2008 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.		\$ 36,880	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>40,552</td><td>8</td></tr> <tr><td>2004</td><td>38,996</td><td>9</td></tr> <tr><td>2005</td><td>40,217</td><td>10</td></tr> <tr><td>2006</td><td>38,304</td><td>11</td></tr> <tr><td>2007</td><td>36,880</td><td>12</td></tr> </table>	2003	40,552	8	2004	38,996	9	2005	40,217	10	2006	38,304	11	2007	36,880	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2007	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2003	40,552	8																																		
2004	38,996	9																																		
2005	40,217	10																																		
2006	38,304	11																																		
2007	36,880	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>36,849.94</u>	\$ <u>36,849.94</u>
2. <u>14-29.0-400-038</u>	<u>LOT/SEC29-SUBL/TWP-1S-BLK</u>	\$ <u>30.50</u>	\$ <u>30.50</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>36,880.44</u>	\$ <u>36,880.44</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 FREEBURG CARE CENTER

0025098 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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>	1
2					2
3	TOTALS	150,000		\$ 22,480	3

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1979	1979	\$ 1,174,206	\$	30	\$ 39,140	\$ 39,140	\$ 1,166,046	4
5	10		1985	1985	227,899		30	7,597	7,597	178,529	5
6			1985	1986	3,116		30	104	104	2,340	6
7			1989	1989	2,110		27	78	78	1,560	7
8	10		1998	1997	411,348		39.5	10,415	10,415	119,721	8
		Improvement Type**									
9		PARKING LOT TITLE INSURANCE		1981	7,109		30	237	237	6,616	9
10		SIDEWALK		1983	908		20			908	10
11		LAUNDRY RENOVATION		1983	3,303		25	69	69	3,303	11
12		STORAGE BUILDING		1983	6,690		20			6,690	12
13		WINDOW REPLACEMENT		1983	967		30	32	32	816	13
14		KITCHEN RENOVATIONS		1983	734		25	23	23	734	14
15		VENTILATION SYSTEM/ INSULATION		1984	1,132		10			1,132	15
16		CONCRETE PAVING		1985	4,124		20			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		15			2,890	21
22		PARKING LOT		1990	11,951		20	598	598	11,063	22
23		SEWER		1990	17,548		25	702	702	12,987	23
24		LIGHTS		1990	1,140		10			1,140	24
25		HEAT PUMPS / COMPRESSOR		1990	2,527		8			2,527	25
26		SEWER REPAIRS / DRIVEWAY REPAIRS / PLUMBING		1991	4,471	28	15		(28)	4,471	26
27		ROOFTOP AIR CONDITIONER		1991	4,600		8			4,600	27
28		FRONT OFFICE REMODELING / DRIVEWAY REPAIRS		1992	10,838		15			10,838	28
29		CARPET		1992	14,036		5			14,036	29
30		PARKING LOT & DRIVEWAY		1993	14,900	501	15	501		14,900	30
31		FENCE / PARKING LOT & DRIVEWAY		1994	6,672	445	15	445		6,453	31
32		CEILING TILE		1994	1,310		5			1,310	32
33		LANDSCAPING		1996	1,499		10			1,499	33
34		WATER HEATER		1996	3,426	228	15	228		2,850	34
35		5 TON CONDENSING UNIT		1996	1,195		10			1,195	35
36		WATER LINE & GAS LINE FOR ADDITION		1997	633		10			633	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 FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$	\$ (83)	\$ 1,244	37
38	CERAMIC TILE & LABOR FOR SHOWERS	1997	5,795	386	10	386		4,439	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	285	5	285		3,277	40
41	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM	1997	503		15			503	41
42	TELEPHONE SYSTEM	1997	4,640		10			4,640	42
43	8 G E HEAT / COOL UNITS	1997	7,624		10			7,624	43
44	cabinets, countertops, & labor for new nurses station and gutting old	1998	6,073	405	15	405		4,252	44
45									45
46	expanded care plan office adding countertop & windows	1998	6,952	463	15	463		4,862	46
47	FIRE ALARM	1998	4,431	295	15	295		3,098	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		2,047	48
49	PHONE JACKS INSTALLED	1998	777	52	15	52		546	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10	198	198	3,884	50
51	replaced ceiling tile & constructed new storage cabinets in activity room	1999	4,951	495	10	495		4,703	51
52									52
53	ROOF TOP FAN	1999	866	58	15	58		551	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		2,147	54
55	NEW ROOF ON WINGS A, B, & C	1999	16,397		10	1,640	1,640	15,580	55
56	WALLPAPER IN DINING ROOM	2000	1,255		5			1,255	56
57	gutted bathroom installed windows & worktop to convert to DON office	2000	2,374	237	10	237		2,015	57
58									58
59	finish DON office- mudd, sand, and paint room, Set cabinets & build shelves. Put carpet & cove base dow & handrail up	2001	2,194	219	10	219		1,643	59
60									60
61	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		877	61
62	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		1,575	62
63									63
64	tear out wall between secretary and bookkeeper office and build countertops and workspace, new carpet, paint, etc.	2003	6,638	664	10	664		3,652	64
65		2004							65
66	BUILD UP ROOF SECTION	2005	8,072	807	10	807		3,632	66
67	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	6,638	6,638	23,233	67
68	firewall laundry room, fire ducts & ceiling tiles in oxygen room	2005	7,588	759	10	759		2,656	68
69	replace smoke detectors		4,457	446	10	446		1,561	69
70	TOTAL (lines 4 thru 69)		\$ 2,139,270	\$ 7,604		\$ 74,964	\$ 67,360	\$ 1,710,095	70

**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:

01/01/2008 Ending: 12/31/2008

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	
1	Totals from Page 12A, Carried Forward		\$ 2,139,270	\$ 7,604		\$ 74,964	\$ 67,360	\$ 1,710,095	1
2	5 TON AIR CONDITIONER	2006	4,621	462	10	462		1,155	2
3	SIDEWALKS, LIGHTING, & LANDSCAPING	2006	16,064		15	1,071	1,071	2,677	3
4	PARKING LOT	2006	6,748		15	450	450	1,125	4
5	REPLACE PARTS OF BACKFLOW PREVENTOR	2007	5,801	580	10	580		870	5
6	LANDSCAPE FRONT OF BUILDING	2007	10,345	1,035	10	1,035		1,552	6
7	REMOVE & REPLACE OLD SIDEWALKS & PARKING LOT	2007	29,079	1,939	15	1,939		2,908	7
8	CANOPY ADDITION	2008	15,191	506	15	506		506	8
9	DAWN TO DUSK LIGHTING	2008	1,543	78	10	77	(1)	77	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	TOTAL (lines 1 thru 33)		\$ 2,228,662	\$ 12,204		\$ 81,084	\$ 68,880	\$ 1,720,965	34

**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: 01/01/2008 Ending: 12/31/2008

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	\$ 122,971	\$ 3,834	\$ 13,922	\$ 10,088	various	\$ 81,308	71
72	Current Year Purchases	8,719	8,719	498	(8,221)	various	498	72
73	Fully Depreciated Assets	423,506				various	423,506	73
74								74
75	TOTALS	\$ 555,196	\$ 12,553	\$ 14,420	\$ 1,867		\$ 505,312	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)	\$ 2,806,338	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,757	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,504	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 70,747	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,226,277	85

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

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

G. Construction-in-Progress

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

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

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

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

0025098

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

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:				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ **28** Description: **CARPET CLEANER**

(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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>we only hire trained aides</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3;39/2	hrs	\$	413	\$ 29,429	\$ 38	413	\$ 29,467	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		63	5,391		63	5,391	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		748	47,450	250	748	47,700	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 prescrpts				44,990		44,990	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): oxygen, tubefeeding, med supplies	39/2								12
13	Other (specify): <u>lab, x-ray, other ancil</u>	39/3				7,236	31,824		39,060	13
14	TOTAL			\$	1,224	\$ 89,506	\$ 77,102	1,224	\$ 166,608	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 **FREEBURG CARE CENTER**# **0025098**Report Period Beginning: **01/01/2008**

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2008**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,839	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	671,954		3
4	Supply Inventory (priced at)	3,055		4
5	Short-Term Investments	150,360		5
6	Prepaid Insurance	18,210		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)	\$ 915,418	\$	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	258,833		15
16	Equipment, at Historical Cost	387,753		16
17	Accumulated Depreciation (book methods)	(553,267)		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)	\$ 93,319	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,008,737	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 68,352	\$	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	57,595		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,136		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	9,652		36
37	ACCRUED LICENSE BED TAX	16,284		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 490,019	\$	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)	\$ 490,019	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 518,718	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,008,737	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 515,750	1
2	Restatements (describe):		2
3	2007 ILLINOIS TAXES PAID	(5,960)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 509,790	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	341,703	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	(332,775)	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)	\$ 8,928	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)	\$ 518,718	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	\$ 3,343,099	1
2	Discounts and Allowances for all Levels	132,809	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,475,908	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	157,960	6
7	Oxygen	43,828	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 201,788	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	3,905	19
20	Radiology and X-Ray	2,725	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,630	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,109	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,109	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)	\$ 3,690,435	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	685,531	31
32	Health Care	1,610,572	32
33	General Administration	596,000	33
B. Capital Expense			
34	Ownership	225,239	34
C. Ancillary Expense			
35	Special Cost Centers	166,608	35
36	Provider Participation Fee	64,782	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,348,732	40
41	Income before Income Taxes (line 30 minus line 40)**	341,703	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 341,703	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: **01/01/2008**

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,948	3,288	\$ 76,843	\$ 23.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,081	1,218	27,345	22.45	3
4	Licensed Practical Nurses	18,981	20,729	370,405	17.87	4
5	CNAs & Orderlies	52,587	56,828	646,772	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,243	3,415	35,667	10.44	9
10	Activity Assistants					10
11	Social Service Workers	2,006	2,156	29,131	13.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,971	2,112	28,144	13.33	14
15	Cook Helpers/Assistants	12,257	13,194	117,937	8.94	15
16	Dishwashers					16
17	Maintenance Workers	3,823	4,100	51,229	12.49	17
18	Housekeepers	9,962	10,909	95,962	8.80	18
19	Laundry	6,023	6,562	58,559	8.92	19
20	Administrator	1,880	2,080	72,636	34.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,518	4,050	56,102	13.85	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>	1,960	2,080	27,122	13.04	33
34	TOTAL (lines 1 - 33)	122,240	132,721	\$ 1,693,854 *	\$ 12.76	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	164	\$ 8,107	1/3	35
36	Medical Director		3,000	9/3	36
37	Medical Records Consultant	16	660	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	966	10/3	39
40	Physical Therapy Consultant	16	996	10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,583	11/3	44
45	Social Service Consultant	25	1,583	10/3	45
46	Other(specify) <u>ADMINISTRATIVE</u>		8,200	17/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	\$ 25,095		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 355	10/3	50
51	Licensed Practical Nurses	5,400	182,724	10/3	51
52	Certified Nurse Assistants/Aides	8,215	167,942	10/3	52
53	TOTAL (lines 50 - 52)	13,623	\$ 351,021		53

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

Report Period Beginning: 01/01/2008 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	PAINTING	2002	\$ 2,141	3	\$ 356	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINTING	2003	1,616	3	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		\$ 1,219	\$ 916	\$ 647	\$ 324	\$	\$	\$	\$	\$

Facility Name & ID Number FREEBURG CARE CENTER

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? 8 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. \$ 64,782
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? NA/ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

FREEBURG CARE CENTER
SCHEDULE OF RECLASSIFICATIONS FOR PGS 3&4 COL #5
12/31/2008
ID # 0025098

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	4269	
10	MEDICAL SUPPLIES		4269
	RECL FOOD SUPPLEMENTS		