

Facility Name & ID Number FREEBURG CARE CENTER

0025098 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF		7,032	1,892	8,924	8
9	SNF/PED					9
10	ICF	15,364	5,616		20,980	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,364	12,648	1,892	29,904	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.43%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 1,892

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: _____

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

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	157,598	8,626	8,180	174,404		174,404	174,404			1
2	Food Purchase		120,536		120,536	2,760	123,296	(708)	122,588		2
3	Housekeeping	94,267	12,506		106,773		106,773	106,773			3
4	Laundry	59,398	9,879		69,277		69,277	69,277			4
5	Heat and Other Utilities			97,651	97,651		97,651	97,651			5
6	Maintenance	44,195	15,902	30,772	90,869		90,869	90,869			6
7	Other (specify):*										7
8	TOTAL General Services	355,458	167,449	136,603	659,510	2,760	662,270	(708)	661,562		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000	3,000			9
10	Nursing and Medical Records	1,181,646	31,752	332,171	1,545,569	(2,760)	1,542,809	1,542,809			10
10a	Therapy			1,258	1,258		1,258	1,258			10a
11	Activities	37,292	3,918	1,566	42,776		42,776	42,776			11
12	Social Services	24,048		1,566	25,614		25,614	25,614			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,242,986	35,670	339,561	1,618,217	(2,760)	1,615,457	1,615,457			16
	C. General Administration										
17	Administrative	85,003		8,300	93,303		93,303	93,303			17
18	Directors Fees			2,800	2,800		2,800	2,800			18
19	Professional Services			136,753	136,753		136,753	136,753			19
20	Dues, Fees, Subscriptions & Promotions			18,697	18,697		18,697	(5,633)	13,064		20
21	Clerical & General Office Expenses	57,631	11,045	6,813	75,489		75,489	(396)	75,093		21
22	Employee Benefits & Payroll Taxes			226,413	226,413		226,413	226,413			22
23	Inservice Training & Education										23
24	Travel and Seminar			5,921	5,921		5,921	5,921			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			72,131	72,131		72,131	72,131			26
27	Other (specify):*										27
28	TOTAL General Administration	142,634	11,045	477,828	631,507		631,507	(6,029)	625,478		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,741,078	214,164	953,992	2,909,234		2,909,234	(6,737)	2,902,497		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: 01/01/2009 Ending: 12/31/2009

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			34,950	34,950		34,950	28,851	63,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,325	12,325		12,325	(12,325)				32
33	Real Estate Taxes			40,420	40,420		40,420		40,420			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			6,600	6,600		6,600		6,600			35
36	Other (specify):*											36
37	TOTAL Ownership			238,295	238,295		238,295	(127,474)	110,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,714	93,608	218,322		218,322		218,322			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		124,714	158,213	282,927		282,927		282,927			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,741,078	338,878	1,350,500	3,430,456		3,430,456	(134,211)	3,296,245			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: **01/01/2009**

Ending: **12/31/2009**

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	5,812	30		9
10	Interest and Other Investment Income	(4,571)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(708)	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	(71)	21		18
19	Entertainment				19
20	Contributions	(325)	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	(5,598)	20		28
29	Other-Attach Schedule	(12,360)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,821)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(116,390)	SCH VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (116,390)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (134,211)		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

FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	DETAIL FOR LINE 29 PAGE 5	\$		1
2				2
3	CHAMBER OF COMMERCE DUES	(35)	20	3
4	INTEREST PAID TO OWNERS ON LOAN	(12,325)	32	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		(12,360)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER# 0025098

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(708)	0	0	0	0	0	0	0	0	0	0	(708)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(708)	0	0	0	0	0	0	0	0	0	0	(708)	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	(5,633)	0	0	0	0	0	0	0	0	0	0	(5,633)	20
21	Clerical & General Office Expenses	(396)	0	0	0	0	0	0	0	0	0	0	(396)	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	(6,029)	0	0	0	0	0	0	0	0	0	0	(6,029)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,737)	0	0	0	0	0	0	0	0	0	0	(6,737)	29

STATE OF ILLINOIS

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

0025098

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	5,812	23,039	0	0	0	0	0	0	0	0	0	28,851	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,896)	4,571	0	0	0	0	0	0	0	0	0	(12,325)	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	(11,084)	(116,390)	0	(127,474)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(17,821)	(116,390)	0	0	0	0	0	0	0	0	0	(134,211)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE OWNER'S LIST ATTACHED				ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
				LAND TRUST		RENTAL

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 144,000	ST. CLAIR ESTATES	100.00%	\$	\$ (144,000)	1
2	V	32 INTEREST EXPENSE		ST. CLAIR ESTATES	100.00%	5,209	5,209	2
3	V	30 DEPRECIATION		ST. CLAIR ESTATES	100.00%	23,039	23,039	3
4	V	32 INTEREST INCOME		ST. CLAIR ESTATES	100.00%	(638)	(638)	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			\$ 27,610	\$ * (116,390)	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: 01/01/2009 Ending: 12/31/2009

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	2,900	17/3	2
3	DALE TOWERS	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	400	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	600	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,100		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: 01/01/2009 Ending: 2/31/2009

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 (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 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.)		\$	39,420	2
3. Under or (over) accrual (line 2 minus line 1).		\$	420	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,000	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.		\$	40,420	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	38,996	8	
	2005	40,217	9	
	2006	38,304	10	
	2007	36,880	11	
	2008	39,420	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>39,420.28</u>	\$ <u>39,420.28</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

01/01/2009 Ending:

12/31/2009

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:

01/01/2009

Ending:

12/31/2009

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	98		1979	1979	\$ 1,174,206	\$	30	\$ 8,160	\$ 8,160	\$ 1,174,206	4
5	10		1985	1985	227,899		30	7,597	7,597	186,126	5
6			1985	1986	3,116		30	104	104	2,444	6
7			1989	1989	2,110		27	78	78	1,638	7
8	10		1998	1997	411,348		39.5	10,415	10,415	130,136	8
	Improvement Type**										
9		PARKING LOT TITLE INSURANCE		1981	7,109		30	237	237	6,853	9
10		SIDEWALK		1983	908		20			908	10
11		LAUNDRY RENOVATION		1983	3,303		25			3,303	11
12		STORAGE BUILDING		1983	6,690		20			6,690	12
13		WINDOW REPLACEMENT		1983	967		30	32	32	848	13
14		KITCHEN RENOVATIONS		1983	734		25			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	11,661	22
23		SEWER		1990	17,548		25	702	702	13,689	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	18	15		(18)	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		15			14,900	30
31		FENCE / PARKING LOT & DRIVEWAY		1994	6,672	219	15	219		6,672	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		3,078	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:

01/01/2009

Ending:

12/31/2009

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		4,825	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	285	5	285		3,562	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		4,657	44
45									45
46	expanded care plan office adding countertop & windows	1998	6,952	463	15	463		5,325	46
47	FIRE ALARM	1998	4,431	295	15	295		3,393	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		2,242	48
49	PHONE JACKS INSTALLED	1998	777	52	15	52		598	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10			3,884	50
51	replaced ceiling tile & constructed new storage cabinets in activity room	1999	4,951	248	10	248		4,951	51
52									52
53	ROOF TOP FAN	1999	866	58	15	58		609	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		2,373	54
55	NEW ROOF ON WINGS A, B, & C	1999	16,397		10	817	817	16,397	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		2,252	57
58									58
59	finish DON office - mudd, sand, and paint room, Set cabinets & build shelves. Put carpet & cove base down & handrail up	2001	2,194	219	10	219		1,862	59
60									60
61	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		994	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		1,785	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		4,316	64
65									65
66	BUILD UP ROOF SECTION	2004	8,072	807	10	807		4,439	66
67	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	6,638	6,638	29,871	67
68	firewall laundry room, fire ducts & ceiling tiles in oxygen room	2005	7,588	759	10	759		3,415	68
69	replace smoke detectors	2005	4,457	446	10	446		2,007	69
70	TOTAL (lines 4 thru 69)		\$ 2,139,270	\$ 6,620		\$ 41,897	\$ 35,277	\$ 1,751,992	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 6,620		\$ 41,897	\$ 35,277	\$ 1,751,992	1
2	5 TON AIR CONDITIONER	2006	4,621	462	10	462		1,617	2
3	SIDEWALKS, LIGHTING, & LANDSCAPING	2006	16,064		15	1,071	1,071	3,748	3
4	PARKING LOT	2006	6,748		15	450	450	1,575	4
5	REPLACE PARTS OF BACKFLOW PREVENTOR	2007	5,801	580	10	580		1,450	5
6	LANDSCAPE FRONT OF BUILDING	2007	10,345	1,035	10	1,035		2,587	6
7	REMOVE & REPLACE OLD SIDEWALKS & PARKING LOT	2007	29,079	1,939	15	1,939		4,847	7
8	CANOPY ADDITION	2008	15,191	1,013	15	1,013		1,519	8
9	DAWN TO DUSK LIGHTING	2008	1,543	154	10	154		231	9
10	2 DOORS REPLACED	2009	3,321	111	15	111		111	10
11	5 TON ROOFTOP UNIT	2009	7,217	361	10	361		361	11
12	ROOFTOP REPAIR WEST WING	2009	7,375	527	7	527		527	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)		\$ 2,246,575	\$ 12,802		\$ 49,600	\$ 36,798	\$ 1,770,565	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 111,742	\$ 3,391	\$ 13,070	\$ 9,679	various	\$ 74,928	71
72	Current Year Purchases	18,757	18,757	1,131	(17,626)	various	1,131	72
73	Fully Depreciated Assets	443,454				various	443,454	73
74								74
75	TOTALS	\$ 573,953	\$ 22,148	\$ 14,201	\$ (7,947)		\$ 519,513	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)	\$ 2,843,008	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,950	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,801	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,851	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,290,078	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:				\$			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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 6,600 Description: CARPET CLEANER (21) WOUND VAC (6510) BI-PAP MACHINE (69)

(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 FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39/3; 39/2	hrs	\$	722	\$ 40,561	\$ 50	722	\$ 40,611	1	
2	Licensed Speech and Language Development Therapist	39/3	hrs		201	18,142		201	18,142	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39/3; 39/2	hrs		835	54,113	300	835	54,413	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				60,549		60,549	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	oxygen, tubefeeding, med supplies, iv's Other (specify): <u>lab, x-ray, other ancil</u>	39/2 39/3				11,898	32,709		44,607	13	
14	TOTAL			\$	1,758	\$ 124,714	\$ 93,608	1,758	\$ 218,322	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(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	\$ 121,697	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	665,799		3
4	Supply Inventory (priced at)	3,055		4
5	Short-Term Investments	167,759		5
6	Prepaid Insurance	12,395		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM BENEFICIARY	710		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 971,415	\$	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	276,746		15
16	Equipment, at Historical Cost	406,510		16
17	Accumulated Depreciation (book methods)	(588,217)		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)	\$ 95,039	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,066,454	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 94,076	\$	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	63,336		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,375		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	8,818		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 503,605	\$	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)	\$ 503,605	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 562,849	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,066,454	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 518,718	1
2	Restatements (describe):		2
3	2008 ILLINOIS TAXES PAID	(5,142)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 513,576	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	274,748	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	(225,475)	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)	\$ 49,273	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)	\$ 562,849	24 *

* This must agree with page 17, line 47.

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	\$	3,300,993	1
2	Discounts and Allowances for all Levels		125,664	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	3,426,657	3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		244,004	6
7	Oxygen		22,024	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	266,028	8
C. Other Operating Revenue				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory		4,924	19
20	Radiology and X-Ray		2,625	20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	7,549	23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***		4,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	4,970	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)	\$	3,705,204	30

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services		659,510	31
32	Health Care		1,618,217	32
33	General Administration		631,507	33
B. Capital Expense				
34	Ownership		238,295	34
C. Ancillary Expense				
35	Special Cost Centers		218,322	35
36	Provider Participation Fee		64,605	36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	3,430,456	40
41	Income before Income Taxes (line 30 minus line 40)**		274,748	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	274,748	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: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,331	3,618	\$ 83,686	\$ 23.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,966	2,129	45,004	21.14	3
4	Licensed Practical Nurses	19,243	20,982	370,418	17.65	4
5	CNAs & Orderlies	50,660	55,190	654,098	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,233	3,437	37,293	10.85	9
10	Activity Assistants					10
11	Social Service Workers	1,530	1,763	24,047	13.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,078	2,279	31,135	13.66	14
15	Cook Helpers/Assistants	12,229	13,726	126,463	9.21	15
16	Dishwashers					16
17	Maintenance Workers	3,120	3,482	44,195	12.69	17
18	Housekeepers	9,678	10,473	94,267	9.00	18
19	Laundry	6,003	6,529	59,398	9.10	19
20	Administrator	1,904	2,080	85,003	40.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,717	4,192	57,631	13.75	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>	1,942	2,111	28,440	13.47	33
34	TOTAL (lines 1 - 33)	120,634	131,991	\$ 1,741,078 *	\$ 13.19	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	160	\$ 8,180	1/3	35
36	Medical Director		3,000	9/3	36
37	Medical Records Consultant	14	540	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	16	1,014	10/3	39
40	Physical Therapy Consultant	17	1,038	10A/3	40
41	Occupational Therapy Consultant	1	24	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	196	10A/3	43
44	Activity Consultant	24	1,566	11/3	44
45	Social Service Consultant	24	1,566	12/3	45
46	Other(specify) <u>ADMINISTRATIVE</u>		8,300	17/3	46
47	<u>BILLING CONSULTANT</u>		582	19/3	47
48	<u>TAX CONSULTANT</u>		4,218	19/3	48
49	TOTAL (lines 35 - 48)	259	\$ 30,224		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	4,534	152,445	10/3	51
52	Certified Nurse Assistants/Aides	8,472	178,172	10/3	52
53	TOTAL (lines 50 - 52)	13,006	\$ 330,617		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		
JOHN HUELSKAMP	ADMINISTRATOR	0	\$ 85,003	Workers' Compensation Insurance	\$ 52,701	IDPH License Fee	\$ 996		
				Unemployment Compensation Insurance	12,426	Advertising: Employee Recruitment	5,598		
				FICA Taxes	133,192	Health Care Worker Background Check			
				Employee Health Insurance	9,957	(Indicate # of checks performed 73)	1,075		
				Employee Meals		Patient Background Checks	81 1,125		
				Illinois Municipal Retirement Fund (IMRF)*		other adv (6437) chamber of comm(35)	6,472		
				401K EXPENSES	11,455	subscrip(379) corp fee(100) bus lic(10)	489		
				VACCINES	294	allscript sub(2167)sams(140)INHAA(100)	2,407		
				EMPLOYEE PARTIES, AWARDS, GIFTS, ETC	6,388	food sanit lic (135) IAPA dues (50)	185		
						kit health inspec(350) elim chamber(35)	315		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(5,598)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 85,003				\$ 226,413			\$ 13,064		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
ADMINISTRATIVE CONSULTANTS	\$ 8,300						Out-of-State Travel	\$	
							In-State Travel	2,072	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		3,849
\$ 8,300				\$			Entertainment Expense		()
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,921
C. Professional Services									
Vendor/Payee	Type	Amount							
JAMESTOWN MANAGEMENT	MANAGEMENT	\$ 129,723							
RICHARD BRESLIN	TAX RETURN PREP	875							
THOMAS LECHIEN	LEGAL FEES	1,355							
GRANT HARTMAN	TAX CONSULTING	4,218							
INNOVATION SOLUTIONS	BILLING CONSULTANT	582							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					
\$ 136,753				\$					

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINTING	2003	\$ 1,616	3	\$ 269	\$	\$	\$	\$	\$	\$	\$
2	PAINTING	2005	1,942	3	647	647	324					
3												
4												
5												
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16												
17												
18												
19												
20	TOTALS		\$ 3,558		\$ 916	\$ 647	\$ 324	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 64,605
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (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.