

Facility Name & ID Number FREEBURG CARE CENTER

0025098 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,275	15,385	1,221	19,881	8
9	SNF/PED					9
10	ICF	11,048	2,620		13,668	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,323	18,005	1,221	33,549	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.89%

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 1,221

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 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	169,077	9,056	9,359	187,492		187,492	187,492		1	
2	Food Purchase		170,247		170,247	3,522	173,769	(942)	172,827	2	
3	Housekeeping	122,598	12,934		135,532		135,532		135,532	3	
4	Laundry	59,756	8,849		68,605		68,605		68,605	4	
5	Heat and Other Utilities			107,693	107,693		107,693		107,693	5	
6	Maintenance	46,688	20,414	35,449	102,551		102,551		102,551	6	
7	Other (specify):*									7	
8	TOTAL General Services	398,119	221,500	152,501	772,120	3,522	775,642	(942)	774,700	8	
	B. Health Care and Programs										
9	Medical Director			4,400	4,400		4,400		4,400	9	
10	Nursing and Medical Records	1,516,320	37,804	298,897	1,853,021	(3,522)	1,849,499		1,849,499	10	
10a	Therapy			2,916	2,916		2,916		2,916	10a	
11	Activities	41,973	4,019	1,648	47,640		47,640		47,640	11	
12	Social Services	36,957		1,648	38,605		38,605		38,605	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,595,250	41,823	309,509	1,946,582	(3,522)	1,943,060		1,943,060	16	
	C. General Administration										
17	Administrative	72,643		11,550	84,193		84,193		84,193	17	
18	Directors Fees			6,000	6,000		6,000		6,000	18	
19	Professional Services			159,238	159,238		159,238		159,238	19	
20	Dues, Fees, Subscriptions & Promotions			23,540	23,540		23,540	(11,208)	12,332	20	
21	Clerical & General Office Expenses	57,730	13,799	14,084	85,613		85,613	(1,177)	84,436	21	
22	Employee Benefits & Payroll Taxes			296,538	296,538		296,538		296,538	22	
23	Inservice Training & Education			132	132		132		132	23	
24	Travel and Seminar			2,983	2,983		2,983		2,983	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			74,000	74,000		74,000		74,000	26	
27	Other (specify):*									27	
28	TOTAL General Administration	130,373	13,799	588,065	732,237		732,237	(12,385)	719,852	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,123,742	277,122	1,050,075	3,450,939		3,450,939	(13,327)	3,437,612	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: 01/01/2013 Ending: 12/31/2013

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			38,879	38,879	38,879	32,243	71,122				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,587	9,587	9,587	(9,425)	162				32
33	Real Estate Taxes			41,870	41,870	41,870		41,870				33
34	Rent-Facility & Grounds			144,000	144,000	144,000	(144,000)					34
35	Rent-Equipment & Vehicles			115	115	115		115				35
36	Other (specify):*											36
37	TOTAL Ownership			234,451	234,451	234,451	(121,182)	113,269				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,875	118,441	168,316	168,316		168,316				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			268,613	268,613	268,613		268,613				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		49,875	387,054	436,929	436,929		436,929				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,123,742	326,997	1,671,580	4,122,319	4,122,319	(134,509)	3,987,810				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: **01/01/2013**

Ending: **12/31/2013**

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	13,669	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(942)	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	(727)	21		18
19	Entertainment				19
20	Contributions	(450)	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	(11,158)	20		28
29	Other-Attach Schedule	(9,475)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,083)		\$	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)	(125,426)	SCHVII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (125,426)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (134,509)		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

FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DETAIL FOR LINE 29 PAGE 5	\$		1
2				2
3	CHAMBER OF COMMERCE DUES	(50)	20	3
4	INTEREST PAID TO OWNER ON LOAN	(9,425)	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		(9,475)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER# 0025098

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(942)	0	0	0	0	0	0	0	0	0	0	(942)	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	(942)	0	(942)	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	(11,208)	0	0	0	0	0	0	0	0	0	0	(11,208)	20
21	Clerical & General Office Expenses	(1,177)	0	0	0	0	0	0	0	0	0	0	(1,177)	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	(12,385)	0	(12,385)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,327)	0	(13,327)	29									

STATE OF ILLINOIS

Facility Name & ID Number FREEBURG CARE CENTER# 0025098

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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	13,669	18,574	0	0	0	0	0	0	0	0	0	32,243	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,425)	0	0	0	0	0	0	0	0	0	0	(9,425)	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	4,244	(125,426)	0	(121,182)	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)	(9,083)	(125,426)	0	0	0	0	0	0	0	0	0	(134,509)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NANCY L. LEONARD	3.45			ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
CHARLES W. BORRENPOHL	3.45			LAND TRUST		RENTAL
LAVONNE KAISER	3.45					
AMY MENGES	3.45					
KATHY L. LICKENBROCK	3.45					
DALE J. LICKENBROCK	3.45					
VERLAN HEBERER	6.9					

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 144,000	ST. CLAIR ESTATES	100.00%	\$	\$ (144,000)	1
2	V	30 DEPRECIATION		ST. CLAIR ESTATES	100.00%	18,574	18,574	2
3	V							3
4	V							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			\$ 18,574	\$ * (125,426)	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:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	FRANK X. HEILIGENSTEIN	3.44						2
3	BARBARA HOLLAND	6.9						3
4	ALICE LANGSTRAAT	6.9						4
5	HERSCHEL PARRISH JR.	13.78						5
6	LARRY RHUTASEL, TRUSTEE	3.45						6
7	MARJORIE RHUTASEL, TRUSTEE	3.45						7
8	JOHN C. SCHAUFLER	20.7						8
9	CAROLYN STUMPF	6.9						9
10	DALE TOWERS DELCARATION OF	6.9						10
11	TRUST							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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. CONS	3.45	NONE	2	5.00	ADM CONS	\$ 7,150	17/3	1
2	JOHN SCHAUFLE	CONSULTANT	ADM. CONS	20.70	NONE	2	5.00	ADM CONS	4,400	17/3	2
3	DALE TOWERS	DIRECTOR	BOARD MEMBE	6.90	NONE	N/A	N/A	director fees	1,200	18/3	3
4	JOHN SCHAUFLE	DIRECTOR	BOARD MEMBE	20.70	NONE	N/A	N/A	director fees	1,200	18/3	4
5	LARRY RHUTASEL	DIRECTOR	BOARD MEMBE	3.45	NONE	N/A	N/A	director fees	1,200	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	BOARD MEMBE	3.44	NONE	N/A	N/A	director fees	1,200	18/3	6
7	CAROLYN STUMPF	DIRECTOR	BOARD MEMBE	6.90	NONE	N/A	N/A	director fees	1,200	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,550		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: 01/01/2013 Ending: 2/31/2013

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

Facility Name & ID Number

FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	CITIZENS COMMUNITY		X	LINE OF CREDIT	INT ONLY		200,000				162					
7	BANK			OPERATING												
8																
9	TOTAL Facility Related						\$ 200,000	\$			\$ 162					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 200,000	\$			\$ 162					

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	41,500		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.)		\$	41,870		2
3. Under or (over) accrual (line 2 minus line 1).		\$	370		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	41,500		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.		\$	41,870		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	39,420	8	FOR BHF USE ONLY	
	2009	40,831	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2010	41,944	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	43,195	11	15	LESS REFUND FROM LINE 6 \$ 15
	2012	41,870	12	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.

2012 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 BRENDA CULLUM
 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 2012 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 2012.

(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-SUBT/TWP-1S-BLK</u>	\$ <u>41,826.16</u>	\$ <u>41,826.16</u>
2. <u>14-29.0-400-038</u>	<u>LOT/SEC-29-SUBT/TWP-1S-BLK</u>	\$ <u>43.70</u>	\$ <u>43.70</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>41,869.86</u></u>	\$ <u><u>41,869.86</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

01/01/2013 Ending:

12/31/2013

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	\$	\$ 1,174,206	4
5	10		1985	1985	227,899		30	7,597	7,597	216,514	5
6			1985	1986	3,116		30	104	104	2,860	6
7			1989	1989	2,110		27	78	78	1,950	7
8	10		1998	1997	411,348		39.5	10,415	10,415	171,796	8
	Improvement Type**										
9		PARKING LOT/TITLE INSURANCE		1981	7,109		30			7,109	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	23	23	967	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		DRIVEWAY		1987	3,990		15			3,990	18
19		DRIVEWAY		1988	1,465		15			1,465	19
20		ENTRY SIGN		1989	2,890		15			2,890	20
21		PARKING LOT		1990	11,951		20			11,951	21
22		SEWER		1990	17,548		25	702	702	16,497	22
23		LIGHTS		1990	1,140		10			1,140	23
24		HEAT PUMPS/COMPRESSOR		1990	2,527		8			2,527	24
25		SEWER REPAIRS/DRIVEWAY REPAIRS/PLUMBING		1991	4,471		15			4,471	25
26		ROOFTOP AIR CONDITIONER		1991	4,600		8			4,600	26
27		FRONT OFFICE REMODELING/ DRIVEWAY REPAIRS		1992	10,838		15			10,838	27
28		CARPET		1992	14,036		5			14,036	28
29		PARKING LOT AND DRIVEWAY		1993	14,900		15			14,900	29
30		FENCE/PARKING LOT & DRIVEWAY		1994	6,672		15			6,672	30
31		CEILING TILE		1994	1,310		5			1,310	31
32		LANDSCAPING		1996	1,499		10			1,499	32
33		WATER HEATER		1996	3,426		15			3,426	33
34		5 TON CONDENSING UNIT		1996	1,195		10			1,195	34
35		WATER LINE & GAS LINE FOR ADDITION		1997	633		10			633	35
36		AIR COMPRESSOR FOR FIRE SYSTEM		1997	1,244		10			1,244	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:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	CERAMIC TILE & LABOR FOR SHOWERS	1997	\$ 5,795	\$	10	\$	\$	\$ 5,795	37
38	ROCK & ROAD GRADING	1997	502		15			502	38
39	REMOVE DRIVEWAY & RECONCRETE	1997	4,274		5			4,274	39
40	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM	1997	503		15			503	40
41	TELEPHONE SYSTEM	1997	4,640		10			4,640	41
42	8 GE HEAT/COOL UNITS	1997	7,624		10			7,624	42
43	cabinets, countertops & labor for new nurses station and	1998	6,073	201	15	201		6,073	43
44	gutting old								44
45	expanded care plan office adding countertop & windows	1998	6,952	238	15	238		6,952	45
46	FIRE ALARM	1998	4,431	153	15	153		4,431	46
47	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	91	15	91		2,918	47
48	PHONE JACKS INSTALLED	1998	777	23	15	23		777	48
49	4 GE HEAT/COOT UNITS	1998	3,884		10			3,884	49
50	replaced ceiling tile & constructed new storage cabinets in	1999	4,951		10			4,951	50
51	activity room								51
52	ROOF TOP FAN	1999	866	58	15	58		841	52
53	WORK ON ROOFTOP A/C UNIT	1999	3,170	119	14	119		3,170	53
54	NEW ROOF ON WINGS A, B & C	1999	16,397		10			16,397	54
55	WALLPAPER IN DINING ROOM	2000	1,255		5			1,255	55
56	guttled bathroom, installed window & worktop to convert to	2000	2,374		10			2,374	56
57	DON office								57
58	Finish DON office - mudd, sand, and paint room, set cabinets	2001	2,194		10			2,194	58
59	& build shelves. Put carpet & cove base down & handrail up								59
60	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		1,462	60
61	remove old shower on D-hall and put in new shower walls	2001	2,097		10			2,097	61
62	and mudd, sand, and paint to seal plaster around shower								62
63	tear out wall between secretary and bookkeeper office	2003	6,638	330	10	330		6,638	63
64	and build countertops and workspace, new carpet, paint, etc								64
65	BUILD UP ROOF SECTION	2004	8,072	807	10	807		7,667	65
66	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	6,638	6,638	56,423	66
67	firewall laundry room, fire ducts & ceiling tiles in oxygen room	2005	7,588	759	10	759		6,451	67
68	replace smoke detectors	2005	4,457	446	10	446		3,791	68
69	5 TON AIR CONDITIONER	2006	4,621	462	10	462		3,465	69
70	TOTAL (lines 4 thru 69)		\$ 2,133,678	\$ 3,804		\$ 29,361	\$ 25,557	\$ 1,867,644	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:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,133,678	\$ 3,804		\$ 29,361	\$ 25,557	\$ 1,867,644	1
2	SIDEWALKS, LIGHTING, & LANDSCAPING	2006	16,064		15	1,071	1,071	8,032	2
3	PARKING LOT	2006	6,748		15	450	450	3,375	3
4	REPLACE PARTS OF BACKFLOW PREVENTOR	2007	5,801	580	10	580		3,770	4
5	LANDSCAPE FRONT OF BUILDING	2007	10,345	1,035	10	1,035		6,727	5
6	REMOVE & REPLACE OLD SIDEWALKS & PARKING LOT	2007	29,079	1,939	15	1,939		12,603	6
7	CANOPY ADDITION	2008	15,191	1,013	15	1,013		5,571	7
8	DAWN TO DUSK LIGHTING	2008	1,543	154	10	154		847	8
9	D2 DOORS REPLACED	2009	3,321	221	15	221		995	9
10	5 TON ROOFTOP UNIT	2009	7,217	722	10	722		3,249	10
11	ROOFTOP REPAIR WEST WING	2009	7,375	1,054	7	1,054		4,743	11
12	remove and redesign nurses station, new cabinets, floor	2010	17,500	1,750	10	1,750		6,125	12
13	and countertops								13
14	repair kitchen wall for damage from leaking, new FRP	2010	3,000	600	5	600		2,100	14
15	covering and covebase and structurally fixed								15
16	2 EXIT DOORS AND HARDWARE	2010	2,408	161	15	161		563	16
17	repair to sprinkler system due to leaking and rusting	2010	3,983	398	10	398		1,393	17
18	replaced piping and got system operational								18
19	52 DOORS AND HINGES	2010	23,732	1,582	15	1,582		5,537	19
20	ALL OTHER DOORS AND HINGES	2011	37,880	2,525	15	2,525		6,313	20
21	FLOORING VCT TILE HALLS A,B,&C	2011	14,004	1,400	10	1,400		3,500	21
22	2 COUNTERTOPS IN KITCHEN	2011	2,807	281	10	281		702	22
23	NEW PART OF PARKING LOT	2011	12,000	800	15	800		2,000	23
24	NEW D HALL ROOF	2011	6,995	700	10	700		1,750	24
25	laundry combustion air and ceiling drywall	2012	13,234	1,323	10	1,323		1,985	25
26	C-HALL ROOF REPLACED	2012	13,000	1,300	10	1,300		1,950	26
27	A-HALL ROOF REPLACED	2012	13,225	1,323	10	1,323		1,984	27
28	REPLACED FRONT ENTRY GLASS	2012	2,055	137	15	137		206	28
29	TEST ON 9 SPRINKLER HEADS & REPLACED	2012	4,360	291	15	291		436	29
30	INSTALL HOT WATER HEATER	2013	8,866	443	10	443		443	30
31	REPLACE DRY SPRINKLER PENDANTS	2013	11,500	575	10	575		575	31
32	REPLACE WINDOWS IN ROOMS 1-7	2013	3,137	157	10	157		157	32
33	INSTALL AIR HANDLER IN JANITORS CLOSET	2013	4,540	114	20	114		114	33
34	TOTAL (lines 1 thru 33)		\$ 2,434,588	\$ 26,382		\$ 53,460	\$ 27,078	\$ 1,955,389	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 165,116	\$	\$ 16,875	\$ 16,875	VARIOUS	\$ 66,658	71
72	Current Year Purchases	12,502	12,497	787	(11,710)	VARIOUS	787	72
73	Fully Depreciated Assets	516,464				VARIOUS	516,464	73
74								74
75	TOTALS	\$ 694,082	\$ 12,497	\$ 17,662	\$ 5,165		\$ 583,909	75

D. Vehicle Costs. (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)	\$ 3,151,150	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,879	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,122	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,243	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,539,298	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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 115 Description: STORAGE 40; CPAP MACHINE 75

(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: 01/01/2013 Ending: 12/31/2013
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>WE ONLY HIRED TRAINED AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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)	\$			

- (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.

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	

- (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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	39/3	hrs	\$	708	\$ 50,640	\$	708	\$ 50,640	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		91	7,561		91	7,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		870	57,708	77	870	57,785	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				32,908		32,908	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 Other (specify): <u>lab, xray, other ancil</u>	39/2 39/3				2,532	16,890		19,422	13
14	TOTAL			\$	1,669	\$ 118,441	\$ 49,875	1,669	\$ 168,316	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: **01/01/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 260,392	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,288,446		3
4	Supply Inventory (priced at)	3,055		4
5	Short-Term Investments	176,807		5
6	Prepaid Insurance	15,787		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)	\$ 1,744,487	\$	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	464,760		15
16	Equipment, at Historical Cost	526,638		16
17	Accumulated Depreciation (book methods)	(785,964)		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): Stor shed in process	(8,973)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,461	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,940,948	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 67,954	\$	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	87,210		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,535		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	10,646		36
37	ACCR OCCUPIED BED TAX	49,216		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 581,061	\$	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)	\$ 581,061	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,359,887	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,940,948	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,291,253	1
2	Restatements (describe):		2
3	2012 Illinois taxes paid	(6,569)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,284,684	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	249,203	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	(174,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 75,203	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)	\$ 1,359,887	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,061,442	1
2	Discounts and Allowances for all Levels	56,353	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,117,795	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,560	6
7	Oxygen	3,665	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 220,225	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	2,190	19
20	Radiology and X-Ray	2,440	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,630	23
D. Non-Operating Revenue			
24	Contributions	3,316	24
25	Interest and Other Investment Income***	25,556	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,872	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)	\$ 4,371,522	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	772,120	31
32	Health Care	1,946,582	32
33	General Administration	732,237	33
B. Capital Expense			
34	Ownership	234,451	34
C. Ancillary Expense			
35	Special Cost Centers	168,316	35
36	Provider Participation Fee	268,613	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,122,319	40
41	Income before Income Taxes (line 30 minus line 40)**	249,203	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 249,203	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,491,948	44
45	Private Pay - Net Inpatient Revenue	2,428,103	45
46	Medicare - Net Inpatient Revenue	263,495	46
47	Other-(specify) VENDING INCOME & PRIOR YEAR ADJUST	(65,751)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,117,795	49

* 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 is deducted on Fed Tax

*** 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: **01/01/2013**

Ending:

12/31/2013

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	3,682	4,256	\$ 106,864	\$ 25.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,213	3,351	91,280	27.24	3
4	Licensed Practical Nurses	23,295	25,188	495,932	19.69	4
5	CNAs & Orderlies	59,545	62,630	788,470	12.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,411	3,655	41,973	11.48	9
10	Activity Assistants					10
11	Social Service Workers	1,900	2,076	36,957	17.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,826	2,078	28,968	13.94	14
15	Cook Helpers/Assistants	13,551	14,323	140,109	9.78	15
16	Dishwashers					16
17	Maintenance Workers	3,109	3,301	46,688	14.14	17
18	Housekeepers	10,734	11,351	122,598	10.80	18
19	Laundry	5,722	6,140	59,756	9.73	19
20	Administrator	1,939	2,080	72,643	34.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,714	4,002	57,730	14.43	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>	1,981	2,165	33,774	15.60	33
34	TOTAL (lines 1 - 33)	137,622	146,596	\$ 2,123,742 *	\$ 14.49	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	191	\$ 9,359	1/3	35
36	Medical Director		4,400	9/3	36
37	Medical Records Consultant	12	580	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,351	10/3	39
40	Physical Therapy Consultant	33	1,835	10A/3	40
41	Occupational Therapy Consultant	16	1,081	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,648	11/3	44
45	Social Service Consultant	25	1,648	12/3	45
46	Other(specify) <u>ADMINISTRATIVE</u>		11,550	17/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	302	\$ 35,452		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	1,523	52,125	10/3	51
52	Certified Nurse Assistants/Aides	11,823	242,841	10/3	52
53	TOTAL (lines 50 - 52)	13,346	\$ 294,966		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	
LAURA NORTHAY	ADMINISTRATOR	0	\$ 72,643	Workers' Compensation Insurance	\$ 53,505	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	53,159	Advertising: Employee Recruitment	3,896	
				FICA Taxes	162,466	Health Care Worker Background Check	756	
				Employee Health Insurance	6,050	(Indicate # of checks performed <u>27</u>)		
				Employee Meals		Patient Background Checks	86 1,305	
				Illinois Municipal Retirement Fund (IMRF)*		other adv (11158) chamber of comm (50)	11,208	
				VACCINES	1,408	subs873 corp fees200 bus lic10 DON 165	1,248	
				EMPLOYEE PARTIES, AWARDS, GIFTS, ETC	7,019	allsc(2391) San lic (138)food san per (375)	2,904	
				401K EXPENSES	12,931	cert diet mgr regis (200) record fee (31)	231	
						elim chamb of comm	(50)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(11,158)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,643	TOTAL (agree to Schedule V, line 22, col.8)	\$ 296,538	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,332	
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			\$ 11,550				Out-of-State Travel	\$
							In-State Travel	1,842
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 11,550				Seminar Expense	1,141
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	()
JAMESTOWN MANAGEMENT	MANAGEMENT		\$ 154,066	TOTAL		\$	TOTAL	2,983
RICHARD BRESLIN	TAX RETURN PREP		945					
SANDBERG PHOENIX	LEGAL		416					
GREENSFELDER, HEMKER, & GALE P.C.	LEGAL		3,811					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 159,238					

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2005	\$ 1,942	3	\$ 647	\$ 324	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 1,942		\$ 647	\$ 324	\$	\$	\$	\$	\$	\$

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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?
If YES, give association name and amount. NO
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 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 _____
- (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. \$ 268,613
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? N/A 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? N/A
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.

FREEBURG CARE CENTER
SCHEDULE OF RECLASSIFICATION FOR PGS 3&4 COL 5
12/31/2013
ID#0025098

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	3522	
10	MEDICAL SUPPLIES		3522
	RECLASSIFY FOOD SUPPLEMENTS		