

Facility Name & ID Number Freeburg Care Center

0025098 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,667</u>	<u>14,373</u>	<u>2,128</u>	<u>23,168</u>	8
9	SNF/PED					9
10	ICF	<u>7,415</u>	<u>2,289</u>		<u>9,704</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,082</u>	<u>16,662</u>	<u>2,128</u>	<u>32,872</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.32%

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 3/16/79

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

YES Date 3/16/79 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 2,111

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Freeburg Care Center

0025098

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	180,204	17,005	12,115	209,324		209,324		209,324		1
2	Food Purchase		187,648		187,648		187,648	(5,022)	182,626		2
3	Housekeeping	143,221	25,078		168,299		168,299		168,299		3
4	Laundry	87,131	23,948	294	111,373		111,373		111,373		4
5	Heat and Other Utilities			140,206	140,206		140,206		140,206		5
6	Maintenance	104,227	71,552	52,020	227,799		227,799		227,799		6
7	Other (specify):* Waste Removal			7,463	7,463		7,463		7,463		7
8	TOTAL General Services	514,783	325,231	212,098	1,052,112		1,052,112	(5,022)	1,047,090		8
	B. Health Care and Programs										
9	Medical Director			7,600	7,600		7,600		7,600		9
10	Nursing and Medical Records	1,947,514	52,321	131,236	2,131,071		2,131,071		2,131,071		10
10a	Therapy			189,056	189,056		189,056		189,056		10a
11	Activities	43,711	10,279	2,696	56,686		56,686	(2,291)	54,395		11
12	Social Services	31,792		1,658	33,450		33,450		33,450		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,023,017	62,600	332,246	2,417,863		2,417,863	(2,291)	2,415,572		16
	C. General Administration										
17	Administrative	86,059			86,059		86,059		86,059		17
18	Directors Fees			15,600	15,600		15,600		15,600		18
19	Professional Services			189,159	189,159		189,159		189,159		19
20	Dues, Fees, Subscriptions & Promotions			29,766	29,766		29,766	(50)	29,716		20
21	Clerical & General Office Expenses	57,764	15,758	10,502	84,024		84,024	(440)	83,584		21
22	Employee Benefits & Payroll Taxes			332,068	332,068		332,068		332,068		22
23	Inservice Training & Education			383	383		383		383		23
24	Travel and Seminar			2,028	2,028		2,028		2,028		24
25	Other Admin. Staff Transportation			1,624	1,624		1,624		1,624		25
26	Insurance-Prop.Liab.Malpractice			85,846	85,846		85,846		85,846		26
27	Other (specify):*										27
28	TOTAL General Administration	143,823	15,758	666,976	826,557		826,557	(490)	826,067		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,681,623	403,589	1,211,320	4,296,532		4,296,532	(7,803)	4,288,729		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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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			31,950	31,950	31,950	45,573	77,523				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,425	9,425	9,425	(9,425)					32
33	Real Estate Taxes			46,660	46,660	46,660		46,660				33
34	Rent-Facility & Grounds			144,000	144,000	144,000	(144,000)					34
35	Rent-Equipment & Vehicles			3,161	3,161	3,161		3,161				35
36	Other (specify):*											36
37	TOTAL Ownership			235,196	235,196	235,196	(107,852)	127,344				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,368		59,368	59,368		59,368				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,692	253,692	253,692		253,692				42
43	Other (specify):* Non-Allowable Cost			25,128	25,128	25,128	(14,980)	10,148				43
44	TOTAL Special Cost Centers		59,368	278,820	338,188	338,188	(14,980)	323,208				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,681,623	462,957	1,725,336	4,869,916	4,869,916	(130,635)	4,739,281				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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	(4,524)	2		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	26,352	30		9
10	Interest and Other Investment Income	(4,364)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(989)	43		13
14	Non-Care Related Interest	(5,061)	32		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	(1,226)	43		18
19	Entertainment				19
20	Contributions	(525)	43		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	(12,240)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(3,279)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,856)		\$	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)	(124,779)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (124,779)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (130,635)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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BHF USE ONLY					
48		49		50	51
					52

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Income	\$ (440)	21	1
2	Chamber of Commerce	(50)	20	2
3	Offset Vending Income	(498)	2	3
4	Offset Activity Income Against Expense	(2,291)	11	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		(3,279)	49

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
See PG 6-Supp		N/A		St. Clair Estate Land Trust	Freeburg	Real Estate

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	30 Depreciation	\$	St. Clair Estates	100.00%	\$ 19,221	\$ 19,221	1
2	V	34 Rent	144,000	St. Clair Estates	100.00%		(144,000)	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			\$ 19,221	\$ * (124,779)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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	John C. Schaufler	20.7						1
2	Herschel Parrish Jr.	13.75						2
3	Verlan Heberer	6.9						3
4	Barbara Holland	6.9						4
5	Alice Langstraat	6.9						5
6	Carolyn Stumpf	6.9						6
7	Dale Towers Declaration of Trust	6.9						7
8	Nancy L. Leonard	3.45						8
9	Charles W. Borrenpohl	3.45						9
10	Lavonne Kaiser	3.45						10
11	Amy Menges	3.45						11
12	Kathy L. Lickenbrock	3.45						12
13	Dale J. Lickenbrock	3.45						13
14	Larry Rhutasel, Trustee	3.45						14
15	Marjorie Rhutasel, Trustee	3.45						15
16	Frank X. Heiligenstein	3.44						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Admin Consultant	3.45	None	2	5.00	Admin Cons.	\$ 9,600	L 19, C3	1
2	John Schaufler	Consultant	Admin Consultant	20.70	None	2	5.00	Admin Cons.	6,000	L 19, C3	2
3	Dale Towers	Director	Board Member	6.90	None	N/A	N/A	Director Fees	3,200	L 18, C3	3
4	John Schaufler	Director	Board Member	20.70	None	N/A	N/A	Director Fees	3,200	L 18, C3	4
5	Larry Rhutasel	Director	Board Member	3.45	None	N/A	N/A	Director Fees	3,200	L 18, C3	5
6	Frank Heiligenstein	Director	Board Member	3.44	None	N/A	N/A	Director Fees	3,200	L 18, C3	6
7	Carolyn Stumpf	Director	Board Member	6.90	None	N/A	N/A	Director Fees	2,800	L 18, C3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 31,200		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

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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

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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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	Shareholder Loan	X		Working Capital	Demand	1/1/94	290,000	290,000	Demand	0.0325	9,425						
7																	
8																	
9	TOTAL Facility Related						\$ 290,000	\$ 290,000			\$ 9,425						
	B. Non-Facility Related*																
10																	
11											(4,364)						
12											(5,061)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (9,425)						
15	TOTALS (line 9+line14)						\$ 290,000	\$ 290,000			\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

2014 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 2014 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 2014.

(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>Long Term Care Property</u>	\$ <u>46,625.32</u>	\$ <u>46,625.32</u>
2. <u>14-29.0-400-038</u>	<u>Long Term Care Property</u>	\$ <u>35.16</u>	\$ <u>35.16</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>46,660.48</u></u>	\$ <u><u>46,660.48</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

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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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	\$ 1,174,206	\$	30	\$	\$	\$ 1,174,206	4
5	10			1985	227,899		30	3,788	3,788	227,899	5
6				1985	3,116		30	104	104	3,068	6
7				1989	2,110		27	78	78	2,106	7
8	10			1997	411,348		39.5	10,415	10,415	192,626	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			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	349	349	17,548	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/15

Ending:

12/31/15

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		15			6,073	43
44	Gutting Old								44
45	Expanded Care Plan Office Adding Countertop & Windows	1998	6,952		15			6,952	45
46	Fire Alarm	1998	4,431		15			4,431	46
47	5 Ton Heating A/c Unit Roof Top	1998	2,918		15			2,918	47
48	Phone Jacks Installed	1998	777		15			777	48
49	4 Ge Heat/cool 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		15			866	52
53	Work On Rooftop A/c Unit	1999	3,170		14			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	Gutted Bathroom, Installed Window & Worktop To Convert	2000	2,374		10			2,374	56
57	to 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		1,696	60
61	Remove Old Shower On D-hall & 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		10			6,638	63
64	Build Countertops And Workspace, New Carpet, Paint, Etc								64
65	Build Up Roof Section	2004	8,072		10			8,072	65
66	New Roof On Flat Part Of Building	2005	66,376		10	3,315	3,315	66,376	66
67	firewall laundry room, fire ducts & ceiling tiles-oxygen room	2005	7,588	378	10	378		7,588	67
68	Replace Smoke Detectors	2005	4,457	220	10	220		4,457	68
69	5 Ton Air Conditioner	2006	4,621	462	10	462		4,389	69
70	TOTAL (lines 4 thru 69)		\$ 2,133,678	\$ 1,177		\$ 19,226	\$ 18,049	\$ 1,914,618	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

1/1/15

Ending:

12/31/15

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	\$ 1,177		\$ 19,226	\$ 18,049	\$ 1,914,618	1
2	Sidewalks, Lighting, & Landscaping	2006	16,064		15	1,071	1,071	10,174	2
3	Parking Lot	2006	6,748		15	450	450	4,275	3
4	Replace Parts Of Backflow Preventor	2007	5,801	580	10	580		4,930	4
5	Landscape Front Of Building	2007	10,345	1,035	10	1,035		8,797	5
6	Remove & Replace Old Sidewalks & Parking Lot	2007	29,079	1,939	15	1,939		16,481	6
7	Canopy Addition	2008	15,191	1,013	15	1,013		7,597	7
8	Dawn To Dusk Lighting	2008	1,543	154	10	154		1,156	8
9	D2 Doors Replaced	2009	3,321	221	15	221		1,437	9
10	5 Ton Rooftop Unit	2009	7,217	722	10	722		4,693	10
11	Rooftop Repair West Wing	2009	7,375	1,054	7	1,054		6,851	11
12	Remove And Redesign Nurses Station, New Cabinets, Floor	2010	17,500	1,750	10	1,750		9,625	12
13	And Countertops								13
14	Repair Kitchen Wall For Damage From Leaking, New Frp	2010	3,000	600	5	300	(300)	3,000	14
15	Covering And Covebase And Structurally Fixed								15
16	2 Exit Doors And Hardware	2010	2,408	161	15	161		885	16
17	Repair To Sprinkler System Due To Leaking And Rusting	2010	3,983	398	10	398		2,189	17
18	Replaced Piping And Got System Operational								18
19	52 Doors And Hinges	2010	23,732	1,582	15	1,582		8,701	19
20	All Other Doors And Hinges	2011	37,880	2,525	15	2,525		11,363	20
21	Flooring Vct Tile Halls A,b,&c	2011	14,004	1,400	10	1,400		6,300	21
22	2 Countertops In Kitchen	2011	2,807	281	10	281		1,264	22
23	New Part Of Parking Lot	2011	12,000	800	15	800		3,600	23
24	New D Hall Roof	2011	6,995	700	10	700		3,150	24
25	Laundry Combustion Air And Ceiling Drywall	2012	13,234	1,323	10	1,323		4,631	25
26	C-hall Roof Replaced	2012	13,000	1,300	10	1,300		4,550	26
27	A-hall Roof Replaced	2012	13,225	1,323	10	1,323		4,630	27
28	Replaced Front Entry Glass	2012	2,055	137	15	137		480	28
29	Test On 9 Sprinkler Heads & Replaced	2012	4,360	291	15	291		1,018	29
30	Install Hot Water Heater	2013	8,866	887	10	887		2,217	30
31	Replace Dry Sprinkler Pendants	2013	11,500	1,150	10	1,150		2,875	31
32	Replace Windows In Rooms 1-7	2013	3,137	314	10	314		785	32
33	Install Air Handler In Janitors Closet	2013	4,540	227	20	227		568	33
34	TOTAL (lines 1 thru 33)		\$ 2,434,588	\$ 25,044		\$ 44,314	\$ 19,270	\$ 2,052,840	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Freeburg Care Center

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 12B, Carried Forward		\$ 2,434,588	\$ 25,044		\$ 44,314	\$ 19,270	\$ 2,052,840	1
2									2
3	Storage Building	2014	2,540	254	20	127	(127)	191	3
4	Carpet in Admin Offices	2014	2,742	548	5	548		822	4
5	B Hall Room Replaced	2014	3,575	358	10	358		537	5
6	Replaced Ceiling Tile and Lights in Lobby Area	2014	5,562	695	8	695		1,043	6
7	Replaced Metal siding on shed	2014	8,850	885	10	885		1,328	7
8	Replaced Roof on Shed	2014	2,637	264	10	264		396	8
9	AC Condensing Unit on D Wing	2014	2,731	273	15	182	(91)	273	9
10	Replace D Hall Flooring Tile	2015	5,327	399	10	266	(133)	266	10
11	Replaced B Hall Bath Flooring and Fixtures	2015	5,872	88	39	147	59	147	11
12	Landscaping	2015	9,740	541	15	487	(54)	487	12
13	Install Roam Alert System-Main Entrance	2015	3,412	114	10	171	57	171	13
14	Installed Electricity to Storage Room (see line 3 above)	2015	1,640	14	10	41	27	41	14
15	Repair to Sprinkler System	2015	5,967	149	10	298	149	298	15
16	Prepping and painting walls, installed blinds in dining and								16
17	admin areas, installed vinyl wall coverings throughout the								17
18	bldg., updated nurses stations, built cabinet for dining area								18
19	and sound systems	2015	140,491	300	39	3,512	3,212	3,512	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)		\$ 2,635,674	\$ 29,926		\$ 52,295	\$ 22,369	\$ 2,062,352	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 200,482	\$	\$ 20,983	\$ 20,983	5-15 Yrs	\$ 104,785	71
72	Current Year Purchases	72,575	2,024	4,245	2,221	10 Years	4,245	72
73	Fully Depreciated Assets	332,122					332,122	73
74	From St Clair Estates	187,737					187,737	74
75	TOTALS	\$ 792,916	\$ 2,024	\$ 25,228	\$ 23,204		\$ 628,889	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	N.A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,451,070 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,950 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,523 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 45,573 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,691,241 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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Lighting	\$ 14,984	92
93	Parking Lot Addition	1,055	93
94			94
95		\$ 16,039	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning: 1/1/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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 N/A.

N/A

N/A

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: \$ 3,161

Description: See Schedule 14A

(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	<u>N/A</u>				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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/15

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

<u>Rental Description</u>	<u>Amount</u>
V-PAP	75
Washing Machine	2,557
Dish Machine	510
Humidifier	19
Total - Line 16	<u><u>3,161</u></u>

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/15 Ending: 12/31/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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)	\$			

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,060	\$ 61,482	\$	1,060	\$ 61,482	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		407	31,026		407	31,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,579	91,269		1,579	91,269	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				47,420		47,420	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	L39(2)					11,948		11,948	12
13	Other (specify):									13
14	TOTAL			\$	3,046	\$ 183,777	\$ 59,368	3,046	\$ 243,145	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning: 1/1/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 376,017	\$ 376,017	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,242,207	1,242,207	3
4	Supply Inventory (priced at <u>Cost</u>)	3,055	3,055	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	817	817	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Capital</u>	20,650	20,650	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,642,746	\$ 1,642,746	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		1,818,679	14
15	Leasehold Improvements, at Historical Cost	665,846	816,995	15
16	Equipment, at Historical Cost	625,470	792,916	16
17	Accumulated Depreciation (book methods)	(871,895)	(2,691,241)	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 (spec <u>Const. in Progress</u>)	16,039	16,039	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 435,460	\$ 753,388	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,078,206	\$ 2,396,134	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 86,326	\$ 86,326	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,999	50,999	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,060	38,060	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,500	41,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	58,913	58,913	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 275,798	\$ 275,798	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	290,000	290,000	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)	\$ 290,000	\$ 290,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 565,798	\$ 565,798	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,512,408	\$ 1,830,336	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,078,206	\$ 2,396,134	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/15

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
MANAGEMENT FEES PAY	13,949	13,949
INSURANCE	1,915	1,915
ACCRUED SALES TAX	259	259
401K LIABILITY	9,422	9,422
PRETAX INSURANCE	1,610	1,610
ACCR LIC BED TAX	31,758	31,758
Total - Line 36	58,913	58,913

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,554,793	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,554,793	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	22,865	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	(65,250)	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)	\$ (42,385)	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)	\$ 1,512,408	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 4,330,891	1
2	Discounts and Allowances for all Levels	127,289	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,458,180	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	358,339	6
7	Oxygen	1,058	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 359,397	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	4,524	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	51,898	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,213	19
20	Radiology and X-Ray	2,673	20
21	Other Medical Services	11,791	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 74,099	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,364	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,364	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	3,229	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,229	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,899,269	30

Note 1-This entity is a cash basis taxpayer

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,052,112	31
32	Health Care	2,417,863	32
33	General Administration	826,557	33
B. Capital Expense			
34	Ownership	235,196	34
C. Ancillary Expense			
35	Special Cost Centers	84,496	35
36	Provider Participation Fee	253,692	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,869,916	40
41	Income before Income Taxes (line 30 minus line 40)**	29,353	41
42	Income Taxes	(6,488)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 22,865	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,683,062	44
45	Private Pay - Net Inpatient Revenue	2,417,125	45
46	Medicare - Net Inpatient Revenue	429,465	46
47	Other-(specify) <u>Prior Year Adjustments</u>	(71,472)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,458,180	49

Note 1 - This entity is a cash basis tax payer

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A-Note 1 If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/15

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
OTHER INCOME	440
ACT & CONT INCOME	2,291
VENDING INCOME	498
Total - Line 28	<u>3,229</u>

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	3,864	4,212	\$ 112,303	\$ 26.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,204	7,727	191,741	24.81	3
4	Licensed Practical Nurses	21,671	23,111	482,605	20.88	4
5	CNAs & Orderlies	81,562	86,085	1,124,638	13.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,751	3,989	43,711	10.96	10
11	Social Service Workers	1,522	1,802	31,792	17.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,923	2,131	34,551	16.21	14
15	Cook Helpers/Assistants	13,662	14,303	145,653	10.18	15
16	Dishwashers					16
17	Maintenance Workers	5,975	6,279	104,227	16.60	17
18	Housekeepers	11,270	12,220	143,221	11.72	18
19	Laundry	7,927	8,507	87,131	10.24	19
20	Administrator	1,332	1,456	86,059	59.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,861	4,189	57,764	13.79	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>	1,951	2,159	36,227	16.78	33
34	TOTAL (lines 1 - 33)	167,475	178,170	\$ 2,681,623 *	\$ 15.05	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	239	\$ 12,115	L1, C3	35
36	Medical Director	Monthly	7,600	L9, C3	36
37	Medical Records Consultant	\$3/Resident	1,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,258	L10, C3	39
40	Physical Therapy Consultant	93	4,645	L10a, C3	40
41	Occupational Therapy Consultant	8	421	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	213	L10a, C3	43
44	Activity Consultant	23	1,658	L11, C3	44
45	Social Service Consultant	23	1,658	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	389	\$ 32,568		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	863	31,515	L10, C3	51
52	Certified Nurse Assistants/Aides	4,281	88,679	L10, C3	52
53	TOTAL (lines 50 - 52)	5,144	\$ 120,194		53

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

