

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0025098</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>FREEBURG CARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>746 URBANNA DRIVE</u> <u>FREEBURG</u> <u>62243</u>																									
Number City Zip Code																									
County: <u>ST. CLAIR</u>																									
Telephone Number: <u>(618) 539-5856</u> Fax # <u>(618) 539-3412</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>ROGER W. BAGLEY</u></td></tr><tr><td>(Title) <u>CONTROLLER</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>ROGER W. BAGLEY</u>	(Title) <u>CONTROLLER</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>ROGER W. BAGLEY</u>																								
	(Title) <u>CONTROLLER</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>03/14/79</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☒ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>ROGER BAGLEY</u> Telephone Number: <u>(618) 549-8331</u> <u>JAMESTOWN MANAGEMENT</u> Email Address: _____																									

Facility Name & ID Number FREEBURG CARE CENTER

0025098 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>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>1,280</u>	<u>1,280</u>	8
9	SNF/PED					9
10	ICF	<u>16,340</u>	<u>15,212</u>		<u>31,552</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,340</u>	<u>15,212</u>	<u>1,280</u>	<u>32,832</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.23%

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

1,280

Medicare Intermediary

CGS

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/11

Fiscal Year:

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	159,109	8,999	8,611	176,719		176,719		176,719			1
2	Food Purchase		145,235		145,235	2,778	148,013	(663)	147,350			2
3	Housekeeping	118,168	11,521		129,689		129,689		129,689			3
4	Laundry	55,574	10,791		66,365		66,365		66,365			4
5	Heat and Other Utilities			105,497	105,497		105,497		105,497			5
6	Maintenance	45,099	25,186	41,493	111,778		111,778		111,778			6
7	Other (specify):*											7
8	TOTAL General Services	377,950	201,732	155,601	735,283	2,778	738,061	(663)	737,398			8
	B. Health Care and Programs											
9	Medical Director			3,700	3,700		3,700		3,700			9
10	Nursing and Medical Records	1,347,600	36,978	263,205	1,647,783	(2,778)	1,645,005		1,645,005			10
10a	Therapy			1,790	1,790		1,790		1,790			10a
11	Activities	41,185	3,042	1,556	45,783		45,783		45,783			11
12	Social Services	30,521		1,555	32,076		32,076		32,076			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,419,306	40,020	271,806	1,731,132	(2,778)	1,728,354		1,728,354			16
	C. General Administration											
17	Administrative	79,306		8,400	87,706		87,706		87,706			17
18	Directors Fees			4,000	4,000		4,000		4,000			18
19	Professional Services			142,113	142,113		142,113		142,113			19
20	Dues, Fees, Subscriptions & Promotions			14,198	14,198		14,198	(4,345)	9,853			20
21	Clerical & General Office Expenses	62,760	13,519	6,314	82,593		82,593	(250)	82,343			21
22	Employee Benefits & Payroll Taxes			270,239	270,239		270,239		270,239			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,690	4,690		4,690		4,690			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,378	72,378		72,378		72,378			26
27	Other (specify):*											27
28	TOTAL General Administration	142,066	13,519	522,332	677,917		677,917	(4,595)	673,322			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,939,322	255,271	949,739	3,144,332		3,144,332	(5,258)	3,139,074			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.

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			70,289	70,289		70,289	(7,762)	62,527			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,513	10,513		10,513	(10,513)				32
33	Real Estate Taxes			41,944	41,944		41,944		41,944			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			190	190		190		190			35
36	Other (specify):*											36
37	TOTAL Ownership			266,936	266,936		266,936	(162,275)	104,661			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,524	122,389	178,913		178,913		178,913			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		56,524	186,994	243,518		243,518		243,518			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,939,322	311,795	1,403,669	3,654,786		3,654,786	(167,533)	3,487,253			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(26,336)	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	(663)	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				18
19	Entertainment				19
20	Contributions	(250)	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	(4,295)	20		28
29	Other-Attach Schedule	(10,563)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,107)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	SCH VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (125,426)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (167,533)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

FREEBURG CARE CENTER

Report Period Beginning:

Ending:

ID#

0025098

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 PAGE 5	\$		1
2				2
3	CHAMBER OF COMMERCE DUES	(50)	20	3
4	INTEREST PAID TO OWNERS ON LOAN	(10,513)	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	(10,563)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

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

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	VERLAN HEBERER	6.9						1
2	FRANK X. HEILIGENTSTEIN	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	6.9						6
7	JOHN C. SCHAUFLE	20.7						7
8	CAROLYN STUMPF	6.9						8
9	DALE TOWERS DECLARATION OF	6.9						9
10	TRUST							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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	6.90	NONE	2	5.00	ADM CONS	\$ 5,400	17/3	1
2	JOHN SCHAUFLER	CONSULTANT	ADM. CONS	20.70	NONE	2	5.00	ADM CONS	3,000	17/3	2
3	DALE TOWERS	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	800	18/3	3
4	JOHN SCHAUFLER	DIRECTOR	board member	20.70	NONE	N/A	N/A	director fees	800	18/3	4
5	LARRY RHUTASEL	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	800	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	board member	3.44	NONE	N/A	N/A	director fees	800	18/3	6
7	CAROLYN STUMPF	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	800	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,400		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

Ending: 2/31/2011

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	NONE						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

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

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

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

B. Real Estate Taxes

		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 2010 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.)			\$	41,944	2
3. Under or (over) accrual (line 2 minus line 1).			\$	444	3
4. Real Estate Tax accrual used for 2011 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.			\$	41,944	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	38,304	8	
		2007	36,880	9	
		2008	39,420	10	
		2009	40,831	11	
		2010	41,944	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>FREEBURG CARE CENTER</u>	COUNTY	<u>ST. CLAIR</u>
FACILITY IDPH LICENSE NUMBER	<u>0025098</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>ROGER BAGLEY</u>		
TELEPHONE	(618) 549-8331	FAX #:	(618) 549-0133

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.

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 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>	<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:

01/01/2011

Ending:

12/31/2011

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	201,320	5
6			1985	1986	3,116		30	104	104	2,652	6
7			1989	1989	2,110		27	78	78	1,794	7
8	10		1998	1997	411,348		39.5	10,415	10,415	150,966	8
	Improvement Type**										
9	PARKING LOT/ TITLE INSURANCE			1981	7,109		30	35	35	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	32	32	912	13
14	KITCHEN RENOVATIONS			1983	734		25			734	14
15	VENTILATION SYSTEM / INSULATION			1984	1,132		10			1,132	15
16	CONCRETE PAVING			1985	4,124		20			4,124	16
17	PARKING LOT			1986	2,518		10			2,518	17
18	STORAGE SHED			1987	10,213		15			10,213	18
19	DRIVEWAY			1988	3,990		15			3,990	19
20	DRIVEWAY			1989	1,465		15			1,465	20
21	ENTRY SIGN			1990	2,890		15			2,890	21
22	PARKING LOT			1990	11,951		20			11,951	22
23	SEWER			1990	17,548		25	702	702	15,093	23
24	LIGHTS			1990	1,140		10			1,140	24
25	HEAT PUMPS / COMPRESSOR			1990	2,527		8			2,527	25
26	SEWER REPAIRS / DRIVEWAY REPAIRS / PLUMBING			1991	4,471		15			4,471	26
27	ROOFTOP AIR CONDITIONER			1991	4,600		8			4,600	27
28	FRONT OFFICE REMODELING / DRIVEWAY REPAIRS			1992	10,838		15			10,838	28
29	CARPET			1992	14,036		5			14,036	29
30	PARKING LOT AND DRIVEWAY			1993	14,900		15			14,900	30
31	FENCE / PARKING LOT & DRIVEWAY			1994	6,672		15			6,672	31
32	CEILING TILE			1994	1,310		5			1,310	32
33	LANDSCAPING			1996	1,499		10			1,499	33
34	WATER HEATER			1996	3,426	120	15	120		3,426	34
35	5 TON CONDENSING UNIT			1996	1,195		10			1,195	35
36	WATER LINE & GAS LINE FOR ADDITION			1997	633		10			633	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FREEBURG CARE CENTER

0025098

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	AIR COMPRESSOR FOR FIRE SYSTEM	1997	\$ 1,244	\$ 83	10	\$	\$ (83)	\$ 1,244	37
38	CERAMIC TIEL & LABOR FOR SHOWERS	1997	5,795	386	10	386		5,597	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	285	5	285		4,132	40
41	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM	1997	503		15			503	41
42	TELEPHONE SYSTEM	1997	4,640		10			4,640	42
43	8 G E HEAT / COOL UNITS	1997	7,624		10			7,624	43
44	cabinets, coutertops, & labor for new nurses station and	1998	6,073	405	15	405		5,467	44
45	gutting old								45
46	expanded care plan office adding countertop & windows	1998	6,952	463	15	463		6,251	46
47	FIRE ALARM	1998	4,431	295	15	295		3,983	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		2,632	48
49	PHONE JACKS INSTALLED	1998	777	52	15	52		702	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10			3,884	50
51	replaced ceiling tile & constructed new storage cabinets in	1999	4,951		10			4,951	51
52	activity room								52
53	ROOF TOP FAN	1999	866	58	15	58		725	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		2,825	54
55	NEW ROOF ON WINGS A,B, & C	1999	16,397		10			16,397	55
56	WALLPAPER IN DINING ROOM	2000	1,255		5			1,255	56
57	gutted bathroom installed windows & worktop to conver to	2000	2,374		10			2,374	57
58	DON office								58
59	finish DON office - mudd, sand, and paint room, set cabinets	2001	2,194	113	10	113		2,194	59
60	& build shelves. Put carpet & cove base down & handrail up								60
61	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		1,228	61
62	remove old shower on d-hall and put in new shower walls	2001	2,097	102	10	102		2,097	62
63	and mudd, sand, and paint to seal plaster around shower								63
64	tear out wall between secretary and bookkeeper office	2003	6,638	664	10	664		5,644	64
65	and build countertoops and workspace, new carpet, paint, etc								65
66	BUILD UP ROOF SECTION	2004	8,072	807	10	807		6,053	66
67	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	6,638	6,638	43,147	67
68	firewall laundry room, fire ducts & ceiling tiles in oxygen room	2005	7,588	759	10	759		4,933	68
69	replace smoke detectors	2005	4,457	446	10	446		2,899	69
70	TOTAL (lines 4 thru 69)		\$ 2,139,270	\$ 5,576		\$ 31,094	\$ 25,518	\$ 1,815,100	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:

01/01/2011 Ending: 12/31/2011

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,139,270	\$ 5,576		\$ 31,094	\$ 25,518	\$ 1,815,100	1
2	5 TON AIR CONDITIONER	2006	4,621	462	10	462		2,541	2
3	SIDEWALKS, LIGHTING, & LANDSCAPING	2006	16,064		15	1,071	1,071	5,890	3
4	PARKING LOT	2006	6,748		15	450	450	2,475	4
5	REPLACE PARTS OF BACKFLOW PREVENTOR	2007	5,801	580	10	580		2,610	5
6	LANDSCAPE FRONT OF BUILDING	2007	10,345	1,035	10	1,035		4,657	6
7	REMOVE & REPLACE OLD SIDEWALKS & PARKING LOT	2007	29,079	1,939	15	1,939		8,725	7
8	CANOPY ADDITION	2008	15,191	1,013	15	1,013		3,545	8
9	DAWN TO DUSK LIGHTING	2008	1,543	154	10	154		539	9
10	2 DOORS REPLACED	2009	3,321	221	15	221		553	10
11	5 TON ROOFTOP UNIT	2009	7,217	722	10	722		1,805	11
12	ROOFTOP REPAIR WEST WING	2009	7,375	1,054	7	1,054		2,635	12
13	remove and redesign nurses station, new cabinets, floor	2010	17,500	1,750	10	1,750		2,625	13
14	and countertops								14
15	repair kitchen wall for damage from leaking, new FRP	2010	3,000	600	5	600		900	15
16	covering and covebase, one structurally fixed								16
17	2 EXIT DOORS AND HARDWARE	2010	2,408	161	15	161		241	17
18	repair to sprinkler system due to leaking and rusting	2010	3,983	398	10	398		597	18
19	replaced piping and got system operational								19
20	52 DOORS AND HINGES	2010	23,732	1,582	15	1,582		2,373	20
21	ALL OTHER DOORS & HINGES	2011	37,880	1,263	10	1,263		1,263	21
22	FLOORING VCT TILE HALLS A,B, & C	2011	14,004	700	10	700		700	22
23	2 COUNTERTOPS IN KITCHEN	2011	2,807	140	15	140		140	23
24	NEW PART OF PARKING LOT	2011	12,000	400	10	400		400	24
25	NEW D HALL ROOF	2011	6,995	350		350		350	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,370,884	\$ 20,100		\$ 47,139	\$ 27,039	\$ 1,860,664	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	\$ 138,306	\$	\$ 12,808	\$ 12,808	various	\$ 72,485	71
72	Current Year Purchases	50,189	50,189	2,580	(47,609)	various	2,580	72
73	Fully Depreciated Assets	474,190				various	474,190	73
74								74
75	TOTALS	\$ 662,685	\$ 50,189	\$ 15,388	\$ (34,801)		\$ 549,255	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)	\$ 3,056,049	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,289	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,527	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,762)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,409,919	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

**

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: \$190
- Description: PRESSURE PAD (50) AIR MATTRESS (110) CARPET CLEANER (30)
- (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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

WE ONLY HIRE TRAINED AIDES

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3	hrs	\$	643	\$ 47,790	\$	643	\$ 47,790	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		115	9,805		115	9,805	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3:39/2	hrs		842	59,717	75	842	59,792	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				36,600		36,600	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
	oxygen, tubefeeding, med supplies, iv's	39/2								
13	Other (specify): lab, xray, other ancil	39/3				5,077	19,849		24,926	13
14	TOTAL			\$	1,600	\$ 122,389	\$ 56,524	1,600	\$ 178,913	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.

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	\$ 60,165	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	945,598		3
4	Supply Inventory (priced at)	3,055		4
5	Short-Term Investments	124,710		5
6	Prepaid Insurance	16,798		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)	\$ 1,150,326	\$	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	401,056		15
16	Equipment, at Historical Cost	495,240		16
17	Accumulated Depreciation (book methods)	(713,971)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 182,325	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,332,651	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,338	\$	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	66,298		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,328		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	<u>401K LIABILITY</u>	11,406		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 522,870	\$	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)	\$ 522,870	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 809,781	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,332,651	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 720,218	1
2	Restatements (describe):		2
3	2010 ILLINOIS TAXES PAID	(6,088)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 714,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	374,776	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	(279,125)	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)	\$ 95,651	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)	\$ 809,781	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,657,117	1
2	Discounts and Allowances for all Levels	109,869	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,766,986	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,860	6
7	Oxygen	17,482	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 251,342	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	1,362	19
20	Radiology and X-Ray	4,324	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,686	23
	D. Non-Operating Revenue		
24	Contributions	1,835	24
25	Interest and Other Investment Income***	3,713	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,548	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)	\$ 4,029,562	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	735,283	31
32	Health Care	1,731,132	32
33	General Administration	677,917	33
	B. Capital Expense		
34	Ownership	266,936	34
	C. Ancillary Expense		
35	Special Cost Centers	178,913	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,654,786	40
41	Income before Income Taxes (line 30 minus line 40)**	374,776	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 374,776	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. IL repl tax deducted on Fed tax return

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

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

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	3,442	3,940	\$ 100,717	\$ 25.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,191	1,327	28,330	21.35	3
4	Licensed Practical Nurses	23,511	25,295	462,615	18.29	4
5	CNAs & Orderlies	54,528	59,463	723,575	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,247	3,502	41,185	11.76	9
10	Activity Assistants					10
11	Social Service Workers	1,797	2,056	30,521	14.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,807	2,121	27,302	12.87	14
15	Cook Helpers/Assistants	12,629	14,237	131,807	9.26	15
16	Dishwashers					16
17	Maintenance Workers	3,269	3,469	45,099	13.00	17
18	Housekeepers	10,769	11,642	118,168	10.15	18
19	Laundry	5,872	6,258	55,574	8.88	19
20	Administrator	1,880	2,080	79,306	38.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,608	4,136	62,760	15.17	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>	2,017	2,209	32,363	14.65	33
34	TOTAL (lines 1 - 33)	129,567	141,735	\$ 1,939,322 *	\$ 13.68	34

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	174	\$ 8,611	1/3	35
36	Medical Director		3,700	9/3	36
37	Medical Records Consultant	16	720	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,240	10/3	39
40	Physical Therapy Consultant	16	979	10A/3	40
41	Occupational Therapy Consultant	8	509	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	302	10A/3	43
44	Activity Consultant	24	1,556	11/3	44
45	Social Service Consultant	24	1,555	12/3	45
46	Other(specify)				46
47	<u>ADMINISTRATIVE</u>		8,400	17/3	47
48	<u>BILLING CONSULTANT</u>		334	19/3	48
49	TOTAL (lines 35 - 48)	266	\$ 29,906		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	1,699	57,983	10/3	51
52	Certified Nurse Assistants/Aides	29,609	201,262	10/3	52
53	TOTAL (lines 50 - 52)	31,308	\$ 259,245		53

* This total must agree with page 4, column 1, line 45.

** 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	Amount of Expense Amortized Per Year								
					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	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2)

Are there any dues to nursing home associations included on the cost report?

NO

If YES, give association name and amount.

N/A
- (3)

Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

8.9 YRS
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

N/A

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

64,605

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

NONE

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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.