

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0025098

Facility Name: Freeburg Care Center

Address: 746 Urbanna Drive Freeburg 62243
Number City Zip Code

County: St Clair

Telephone Number: (618) 539-5856 Fax # (618) 539-3412

HFS ID Number:

Date of Initial License for Current Owners: 3/14/79

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 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.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

#	0025098	Report Period Beginning:	1/1/16	Ending:	12/31/16
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

None

Yes

YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

YES ☐ NO ☒

Date started 3/16/79

YES ☒ Date 3/16/79 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 2,128

IV. ACCOUNTING BASIS

ACCRUAL	☒	MODIFIED		
CASH*	☐	CASH*	☐	

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

Tax Year: 12/31 **Fiscal Year:** 12/31

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

SEE ACCOUNTANTS' PREPARATION REPORT

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		13,010	2,330	15,340	8
9	SNF/PED					9
10	ICF	14,039	3,344		17,383	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,039	16,354	2,330	32,723	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.77%

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	194,187	11,915	10,581	216,683		216,683		216,683			1
2	Food Purchase		200,736		200,736		200,736	(2,762)	197,974			2
3	Housekeeping	169,847	23,069		192,916		192,916		192,916			3
4	Laundry	86,677	33,081		119,758		119,758		119,758			4
5	Heat and Other Utilities			131,417	131,417		131,417		131,417			5
6	Maintenance	114,863	67,241	63,793	245,897		245,897		245,897			6
7	Other (specify):* Waste Removal			8,641	8,641		8,641		8,641			7
8	TOTAL General Services	565,574	336,042	214,432	1,116,048		1,116,048	(2,762)	1,113,286			8
	B. Health Care and Programs											
9	Medical Director			11,600	11,600		11,600		11,600			9
10	Nursing and Medical Records	2,029,401	67,171	161,264	2,257,836		2,257,836		2,257,836			10
10a	Therapy			6,715	6,715		6,715		6,715			10a
11	Activities	51,245	12,824	2,713	66,782		66,782	(520)	66,262			11
12	Social Services	40,603		1,629	42,232		42,232		42,232			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,121,249	79,995	183,921	2,385,165		2,385,165	(520)	2,384,645			16
	C. General Administration											
17	Administrative	99,203			99,203		99,203		99,203			17
18	Directors Fees			10,400	10,400		10,400		10,400			18
19	Professional Services			202,171	202,171		202,171	845	203,016			19
20	Dues, Fees, Subscriptions & Promotions			25,622	25,622		25,622	99	25,721			20
21	Clerical & General Office Expenses	64,614	21,993	17,614	104,221		104,221	(878)	103,343			21
22	Employee Benefits & Payroll Taxes			372,204	372,204		372,204		372,204			22
23	Inservice Training & Education			1,696	1,696		1,696		1,696			23
24	Travel and Seminar			1,163	1,163		1,163		1,163			24
25	Other Admin. Staff Transportation			1,891	1,891		1,891		1,891			25
26	Insurance-Prop.Liab.Malpractice			85,783	85,783		85,783		85,783			26
27	Other (specify):*											27
28	TOTAL General Administration	163,817	21,993	718,544	904,354		904,354	66	904,420			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,850,640	438,030	1,116,897	4,405,567		4,405,567	(3,216)	4,402,351			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			48,879	48,879		48,879	36,305	85,184			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,807	15,807		15,807	(11,350)	4,457			32
33	Real Estate Taxes			58,062	58,062		58,062		58,062			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			9,612	9,612		9,612		9,612			35
36	Other (specify):*											36
37	TOTAL Ownership			276,360	276,360		276,360	(119,045)	157,315			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			164	164		164		164			38
39	Ancillary Service Centers		79,349	300,764	380,113		380,113		380,113			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			249,450	249,450		249,450		249,450			42
43	Other (specify):* Disallowed Costs			34,327	34,327		34,327	(25,552)	8,775			43
44	TOTAL Special Cost Centers		79,349	584,705	664,054		664,054	(25,552)	638,502			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,850,640	517,379	1,977,962	5,345,981		5,345,981	(147,813)	5,198,168			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Freeburg Care Center

Period Beginning 1/1/16
Period End 12/31/16

Schedule 4A

V. Cost Center Expenses

		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	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			5,619	5,619		5,619		5,619			
	Radiology Expenses			3,156	3,156		3,156		3,156			
	Non-Allowable Expenses			25,552	25,552		25,552	(25,552)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	34,327	34,327	0	34,327	(25,552)	8,775			

SEE ACCOUNTANTS' COMPILATION REPORT

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	(1,983)	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	24,317	30		9
10	Interest and Other Investment Income	(787)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,126)	43		13
14	Non-Care Related Interest	(11,900)	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	(2,835)	43		18
19	Entertainment				19
20	Contributions	(364)	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	(21,227)	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	(2,201)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,106)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(129,707)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (129,707)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,813)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income	\$ (902)	21	1
2	Offset Vending Income	(779)	2	2
3	Offset Activity Income Against Expense	(520)	11	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				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	(2,201)		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		N/A		

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	19	Professional Services	\$	St. Clair Estates	100.00%	\$ 845	\$ 845	1
2	V	20	Dues, Fees, Subscriptions		St. Clair Estates	100.00%	99	99	2
3	V	21	Clerical & General Office Exp		St. Clair Estates	100.00%	24	24	3
4	V	30	Depreciation		St. Clair Estates	100.00%	11,988	11,988	4
5	V	32	Interest Expense		St. Clair Estates	100.00%	1,337	1,337	5
6	V	34	Rent	144,000	St. Clair Estates	100.00%		(144,000)	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			\$ 14,293	\$ * (129,707)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Vice President	Board Member	6.90	None	N/A	N/A	Director Fees	1,600	L 18, C3	3
4	John Schaufler	President	Board Member	20.70	None	N/A	N/A	Director Fees	2,400	L 18, C3	4
5	Larry Rhutasel	Sec/Treasurer	Board Member	3.45	None	N/A	N/A	Director Fees	2,400	L 18, C3	5
6	Frank Heiligenstein	Director	Board Member	3.44	None	N/A	N/A	Director Fees	2,400	L 18, C3	6
7	Carolyn Stumpf	Director	Board Member	6.90	None	N/A	N/A	Director Fees	1,600	L 18, C3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Citizens Bank		X	Renovation	Interest Only	Various	\$ 518,000	\$ 518,000		0.0500	\$ 4,457	1	
2	St Clair Estates Land Trust	X		Renovation	Interest Only	Various	125,000	125,000	Demand	0.0500		2	
3												3	
4												4	
5												5	
	Working Capital												
6	Shareholder Loan	X		Working Capital	Demand	1/1/94	290,000	290,000	Demand	0.0325	12,687	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 933,000	\$ 933,000			\$ 17,144	9	
	B. Non-Facility Related*												
10												10	
11								Offset Interest Income			(787)	11	
12								Disallow Related Party Interest Exp			(11,900)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (12,687)	14	
15	TOTALS (line 9+line14)						\$ 933,000	\$ 933,000			\$ 4,457	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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' PREPARATION REPORT

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

B. Real Estate Taxes

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.

HFS 3745 (N-4-99)

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

Enter the tax index number and real estate tax assessed for 2015 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 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.

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 (X) (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? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	150,000	1979	\$ 22,480	1
2					2
3	TOTALS	150,000		\$ 22,480	3

SEE ACCOUNTANTS' PREPARATION REPORT

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			227,899	5
6				1985	3,116		30	48	48	3,116	6
7				1989	2,110		27	4	4	2,110	7
8	10			1997	411,348		39.5	10,415	10,415	203,041	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			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' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/16

Ending:

12/31/16

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/coot Units	1998	3,884		10			3,884	49
50	Replaced Ceiling Tile&Constructed New Storage Cabinets In	1999	4,951		10			4,951	50
51	Activity Room								51
52	Roof Top Fan	1999	866		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	54	15	54		1,750	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			66,376	66
67	firewall laundry room, fire ducts & ceiling tiles-oxygen room	2005	7,588		10			7,588	67
68	Replace Smoke Detectors	2005	4,457		10			4,457	68
69	5 Ton Air Conditioner	2006	4,621	232	10	232		4,621	69
70	TOTAL (lines 4 thru 69)		\$ 2,133,678	\$ 286		\$ 10,753	\$ 10,467	\$ 1,925,371	70

SEE ACCOUNTANTS' PREPARATION 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:

1/1/16

Ending:

12/31/16

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	
1	Totals from Page 12A, Carried Forward		\$ 2,133,678	\$ 286		\$ 10,753	\$ 10,467	\$ 1,925,371	1
2	Sidewalks, Lighting, & Landscaping	2006	16,064		15	1,071	1,071	11,245	2
3	Parking Lot	2006	6,748		15	450	450	4,725	3
4	Replace Parts Of Backflow Preventor	2007	5,801	580	10	580		5,510	4
5	Landscape Front Of Building	2007	10,345	1,035	10	1,035		9,832	5
6	Remove & Replace Old Sidewalks & Parking Lot	2007	29,079	1,939	15	1,939		18,420	6
7	Canopy Addition	2008	15,191	1,013	15	1,013		8,610	7
8	Dawn To Dusk Lighting	2008	1,543	154	10	154		1,310	8
9	D2 Doors Replaced	2009	3,321	221	15	221		1,658	9
10	5 Ton Rooftop Unit	2009	7,217	722	10	722		5,415	10
11	Rooftop Repair West Wing	2009	7,375	524	7	524		7,375	11
12	Remove And Redesign Nurses Station, New Cabinets, Floor	2010	17,500	1,750	10	1,750		11,375	12
13	And Countertops								13
14	Repair Kitchen Wall For Damage From Leaking, New Frp	2010	3,000	600	5		(600)	3,000	14
15	Covering And Covebase And Structurally Fixed								15
16	2 Exit Doors And Hardware	2010	2,408	161	15	161		1,046	16
17	Repair To Sprinkler System Due To Leaking And Rusting	2010	3,983	398	10	398		2,587	17
18	Replaced Piping And Got System Operational								18
19	52 Doors And Hinges	2010	23,732	1,582	15	1,582		10,283	19
20	All Other Doors And Hinges	2011	37,880	2,525	15	2,525		13,888	20
21	Flooring Vct Tile Halls A,b,&c	2011	14,004	1,400	10	1,400		7,700	21
22	2 Countertops In Kitchen	2011	2,807	281	10	281		1,545	22
23	New Part Of Parking Lot	2011	12,000	800	15	800		4,400	23
24	New D Hall Roof	2011	6,995	700	10	700		3,850	24
25	Laundry Combustion Air And Ceiling Drywall	2012	13,234	1,323	10	1,323		5,954	25
26	C-hall Roof Replaced	2012	13,000	1,300	10	1,300		5,850	26
27	A-hall Roof Replaced	2012	13,225	1,323	10	1,323		5,953	27
28	Replaced Front Entry Glass	2012	2,055	137	15	137		617	28
29	Test On 9 Sprinkler Heads & Replaced	2012	4,360	291	15	291		1,309	29
30	Install Hot Water Heater	2013	8,866	887	10	887		3,104	30
31	Replace Dry Sprinkler Pendants	2013	11,500	1,150	10	1,150		4,025	31
32	Replace Windows In Rooms 1-7	2013	3,137	314	10	314		1,099	32
33	Install Air Handler In Janitors Closet	2013	4,540	227	20	227		795	33
34	TOTAL (lines 1 thru 33)		\$ 2,434,588	\$ 23,623		\$ 35,011	\$ 11,388	\$ 2,087,851	34

SEE ACCOUNTANTS' PREPARATION 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:

1/1/16

Ending:

12/31/16

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	
1	Totals from Page 12B, Carried Forward		\$ 2,434,588	\$ 23,623		\$ 35,011	\$ 11,388	\$ 2,087,851	1
2	Storage Building	2014	2,540	254	20	127	(127)	318	2
3	Carpet in Admin Offices	2014	2,742	548	5	548		1,370	3
4	B Hall Room Replaced	2014	3,575	358	10	358		895	4
5	Replaced Ceiling Tile and Lights in Lobby Area	2014	5,562	695	8	695		1,738	5
6	Replaced Metal siding on shed	2014	8,850	885	10	885		2,213	6
7	Replaced Roof on Shed	2014	2,637	264	10	264		660	7
8	AC Condensing Unit on D Wing	2014	2,731	273	15	182	(91)	455	8
9	Replace D Hall Flooring Tile	2015	5,327	932	10	533	(399)	799	9
10	Replaced B Hall Bath Flooring and Fixtures	2015	5,872	239	39	294	55	441	10
11	Landscaping	2015	9,740	1,190	15	974	(216)	1,461	11
12	Install Roam Alert System-Main Entrance	2015	3,412	455	10	341	(114)	512	12
13	Installed Electricity to Storage Room (see line 3 above)	2015	1,640	178	10	82	(96)	123	13
14	Repair to Sprinkler System	2015	5,967	746	10	597	(149)	895	14
15	Prepping and painting walls, installed blinds in dining and								15
16	admin areas, installed vinyl wall coverings throughout the								16
17	bldg., updated nurses stations, built cabinet for dining area								17
18	and sound systems	2015	140,491	3,902	39	7,024	3,122	3,512	18
19	Replaced Lighting Throughout Halls/Dining Areas/Nurses Station	2016	19,816	475	10	991	516	991	19
20	Sprinkler system improvements including new compressor	2016	6,210	149	15	207	58	207	20
21	Installed 62 blinds in resident rooms	2016	6,264	313	10	313		313	21
22	Prep and paint walls and ceilings in nurses station and halls,								22
23	eating area, paint door frames and fire doors	2016	5,275	126	5	528	402	528	23
24	Installed 43 Privacy Curtains	2016	4,798	240	5	480	240	480	24
25	Signage in Building	2016	2,839	142	5	284	142	284	25
26	Removed and replaced bushes, rock, mulch	2016	3,733	124	10	187	63	187	26
27	Installed New Windows in Resident Rooms	2016	17,997	431	30	300	(131)	300	27
28	Replaced compressor on roof top A/C unit	2016	2,725	65	15	91	26	91	28
29	Awnings over serving windows in dining room	2016	6,722	336	5	672	336	672	29
30	Remove and replace vinyl tile in rooms D10-11	2016	2,730	137	10	137		137	30
31	Shower Room Remodel-Removed and replaced drywall, floor								31
32	and shower tile, painted walls, repaired plumbing, sink,								32
33	fixtures, grab bars, shelving, toilet and cabinet	2016	23,972	574	20	600	26	600	33
34	TOTAL (lines 1 thru 33)		\$ 2,738,755	\$ 37,654		\$ 52,705	\$ 15,051	\$ 2,108,033	34

SEE ACCOUNTANTS' PREPARATION 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:

1/1/16

Ending:

12/31/16

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 12C, Carried Forward		\$ 2,738,755	\$ 37,654		\$ 52,705	\$ 15,051	\$ 2,108,033	1
2	Installed Wireless Access Point System	2016	4,100	410	5	410		410	2
3	Entrance Sign by Road	2016	5,800	290	10	290		290	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,748,655	\$ 38,354		\$ 53,405	\$ 15,051	\$ 2,108,733	34

SEE ACCOUNTANTS' PREPARATION 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	\$271,767	\$6,658	\$28,019	\$21,361	5-15 Yrs	\$135,759	71
72	Current Year Purchases	77,362	3,867	3,760	(107)	5-12 Yrs	3,760	72
73	Fully Depreciated Assets	333,412					333,412	73
74	From St Clair Estates	187,737					187,737	74
75	TOTALS	\$870,278	\$10,525	\$31,779	\$21,254		\$660,668	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	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)	\$3,641,413	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$48,879	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$85,184	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$36,305	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,769,401	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		\$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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: \$ 9,612 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	N/A				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' PREPARATION REPORT

Facility Name:Freeburg Care Center

IDPH License ID Number:0025098

Fiscal Year End:12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Mattress	2,401
Washing Machine	4,999
Dish Machine	2,062
Wheelchair	150
Total - Line 16	9,612

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

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)	\$			

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' PREPARATION REPORT

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	10A(3)	hrs	\$	1,516	\$ 92,005	\$	1,516	\$ 92,005	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		671	47,081		671	47,081	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,904	161,678		2,904	161,678	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				60,153		60,153	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					19,196		19,196	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	5,091	\$ 300,764	\$ 79,349	5,091	\$ 380,113	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' PREPARATION REPORT

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	\$ 28,056	\$ 28,056	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	2,146,387	2,146,387	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	2,621	2,621	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)	\$ 2,200,769	\$ 2,200,769	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	778,827	929,976	15
16	Equipment, at Historical Cost	702,832	870,278	16
17	Accumulated Depreciation (book methods)	(920,774)	(2,769,401)	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):	8,941	8,941	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 569,826	\$ 858,473	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,770,595	\$ 3,059,242	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 129,199	\$ 129,199	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,204	76,204	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,857	41,857	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000	50,000	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>	78,460	78,460	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 375,720	\$ 375,720	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	933,000	933,000	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)	\$ 933,000	\$ 933,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,308,720	\$ 1,308,720	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,461,875	\$ 1,750,522	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,770,595	\$ 3,059,242	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/16

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
MANAGEMENT FEES PAY	33,551	33,551
INSURANCE	1,347	1,347
ACCRUED SALES TAX	421	421
401K LIABILITY	9,636	9,636
PRETAX INSURANCE	763	763
ACCRUED INTEREST	2,537	2,537
ACCR LIC BED TAX	30,205	30,205
Total - Line 36	78,460	78,460

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,512,408	1
2	Restatements (describe):		2
3	Miscellaneous Difference	(349)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,512,059	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(50,184)	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	()	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)	\$ (50,184)	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)	\$ 1,461,875	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning: 1/1/16

Ending: 12/31/16

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	\$ 4,591,187	1
2	Discounts and Allowances for all Levels	123,065	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,714,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	479,761	6
7	Oxygen	14,855	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 494,616	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	1,983	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,893	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,400	19
20	Radiology and X-Ray	3,750	20
21	Other Medical Services	9,915	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 83,941	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	787	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 787	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	2,201	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,201	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,295,797	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,116,048	31
32	Health Care	2,385,165	32
33	General Administration	904,354	33
	B. Capital Expense		
34	Ownership	276,360	34
	C. Ancillary Expense		
35	Special Cost Centers	414,604	35
36	Provider Participation Fee	249,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,345,981	40
41	Income before Income Taxes (line 30 minus line 40)**	(50,184)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (50,184)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,767,500	44
45	Private Pay - Net Inpatient Revenue	2,535,231	45
46	Medicare - Net Inpatient Revenue	465,575	46
47	Other-(specify) <u>Prior Year Adjustments</u>	(54,054)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,714,252	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' PREPARATION REPORT

Facility Name:

Freeburg Care Center

IDPH License ID Number:

0025098

Fiscal Year End:

12/31/16

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
OTHER INCOME	902
ACT & CONT INCOME	520
VENDING INCOME	779
Total - Line 28	2,201

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	3,959	4,468	\$ 118,349	\$ 26.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,598	6,059	152,173	25.12	3
4	Licensed Practical Nurses	27,180	28,919	585,669	20.25	4
5	CNAs & Orderlies	84,853	90,042	1,134,471	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,456	4,727	51,245	10.84	10
11	Social Service Workers	1,568	1,616	40,603	25.13	11
12	Dietician					12
13	Food Service Supervisor	1,961	2,157	33,758	15.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,528	16,375	160,429	9.80	15
16	Dishwashers					16
17	Maintenance Workers	7,537	8,074	114,863	14.23	17
18	Housekeepers	14,092	15,317	169,847	11.09	18
19	Laundry	8,221	8,898	86,677	9.74	19
20	Administrator	1,975	2,169	99,203	45.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,066	4,721	64,614	13.69	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)Ward Clerk	2,057	2,290	38,739	16.92	33
34	TOTAL (lines 1 - 33)	183,051	195,832	\$ 2,850,640 *	\$ 14.56	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	210	\$ 10,581	L1,C3	35
36	Medical Director	Monthly	11,600	L9,C3	36
37	Medical Records Consultant	12	660	L10,C3	37
38	Nurse Consultant	149	12,728	L10,C3	38
39	Pharmacist Consultant	Monthly	3,012	L10,C3	39
40	Physical Therapy Consultant	133	6,579	L10A,C3	40
41	Occupational Therapy Consultant	1	47	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	89	L10A,C3	43
44	Activity Consultant	25	1,629	L11,C3	44
45	Social Service Consultant	25	1,629	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	556	\$ 48,554		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	634	22,387	L10, C3	51
52	Certified Nurse Assistants/Aides	5,643	119,726	L10, C3	52
53	TOTAL (lines 50 - 52)	6,277	\$ 142,113		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Lewis Schweizer	Administrator	0	\$ 5,748	Workers' Compensation Insurance	\$	84,789	IDPH License Fee	\$ 1,992	
Amy Bonta	Administrator	0	93,455	Unemployment Compensation Insurance		30,707	Advertising: Employee Recruitment	14,861	
				FICA Taxes		218,074	Health Care Worker Background Check		
				Employee Health Insurance		6,940	(Indicate # of checks performed 16)	464	
				Employee Meals			Patient Background Checks 117	1,208	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	1,349	
				Vaccines		3,773	Miscellaneous Subscriptions	3,431	
				Drug Testing		4,571	All Scripts	2,416	
				401(k) Expense		10,206			
				Christmas Gifts/Cards		5,873			
				Other Employee Benefits		7,271			
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 99,203				Non-allowable advertising	()	
B. Administrative - Other							Yellow page advertising	()	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 372,204		
N/A			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
				Description			Line #	Amount	
				Description				Amount	
				N/A					

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0025098

Report Period Beginning:

1/1/16

Ending:

Page 22

12/31/16

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. 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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. \$ None Line N/A
- (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. N/A
- (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.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. \$ 249,450
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,983
- (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? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees