

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: Saint 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

X PROPRIETARY
Individual
Partnership
Corporation
X "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 1/1/2025 to 12/31/2025 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 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				7		6,463	988	7,458	8
9	SNF/PED									9
10	ICF	2,891	6,947	212		17,469			27,519	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,891	6,947	212	7	17,469	6,463	988	34,977	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.21%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location? Date started 3/16/79

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 3/16/79 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 92

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	503,419	32,046	15,874	551,339		551,339		551,339			1
2	Food Purchase		341,974		341,974		341,974	(9,009)	332,965			2
3	Housekeeping	322,941	40,596		363,537		363,537		363,537			3
4	Laundry	142,272	50,984		193,256		193,256		193,256			4
5	Heat and Other Utilities			219,435	219,435		219,435		219,435			5
6	Maintenance	84,376	53,379	94,544	232,299		232,299		232,299			6
7	Other (specify):* Waste Disposal			24,718	24,718		24,718	(14)	24,704			7
8	TOTAL General Services	1,053,008	518,979	354,571	1,926,558		1,926,558	(9,023)	1,917,535			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,196,718	107,699	760,262	4,064,679		4,064,679		4,064,679			10
10a	Therapy											10a
11	Activities	284,264	13,804	18,084	316,152		316,152	(8,396)	307,756			11
12	Social Services	103,262		600	103,862		103,862		103,862			12
13	CNA Training											13
14	Program Transportation			4,666	4,666		4,666		4,666			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,584,244	121,503	801,612	4,507,359		4,507,359	(8,396)	4,498,963			16
	C. General Administration											
17	Administrative	130,457			130,457		130,457		130,457			17
18	Directors Fees			6,000	6,000		6,000		6,000			18
19	Professional Services			168,844	168,844		168,844	2,127	170,971			19
20	Dues, Fees, Subscriptions & Promotions			19,811	19,811		19,811	(3,969)	15,842			20
21	Clerical & General Office Expenses	234,915	44,296	16,697	295,908		295,908	(305)	295,603			21
22	Employee Benefits & Payroll Taxes			727,310	727,310		727,310	(477)	726,833			22
23	Inservice Training & Education			954	954		954		954			23
24	Travel and Seminar			2,884	2,884		2,884		2,884			24
25	Other Admin. Staff Transportation			4,737	4,737		4,737		4,737			25
26	Insurance-Prop.Liab.Malpractice			191,385	191,385		191,385		191,385			26
27	Other (specify):*											27
28	TOTAL General Administration	365,372	44,296	1,138,622	1,548,290		1,548,290	(2,624)	1,545,666			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,002,624	684,778	2,294,805	7,982,207		7,982,207	(20,043)	7,962,164			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			68,067	68,067		68,067	10,884	78,951			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,353	8,353		8,353	(3,397)	4,956			32
33	Real Estate Taxes			65,860	65,860		65,860		65,860			33
34	Rent-Facility & Grounds			174,000	174,000		174,000	(174,000)				34
35	Rent-Equipment & Vehicles			54,240	54,240		54,240		54,240			35
36	Other (specify):*											36
37	TOTAL Ownership			370,520	370,520		370,520	(166,513)	204,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			888	888		888		888			38
39	Ancillary Service Centers		212,617	670,381	882,998		882,998		882,998			39
40	Barber and Beauty Shops			19,369	19,369		19,369		19,369			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			524,236	524,236		524,236		524,236			42
43	Other (specify):* See Att Sch 4A	71,679		308,552	380,231		380,231	(344,750)	35,481			43
44	TOTAL Special Cost Centers	71,679	212,617	1,523,426	1,807,722		1,807,722	(344,750)	1,462,972			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,074,303	897,395	4,188,751	10,160,449		10,160,449	(531,306)	9,629,143			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 1/1/2025
Period End 12/31/2025

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):*				-		-		-			
	Laboratory/Expenses			19,642	19,642		19,642		19,642			
	Radiology Expenses			15,839	15,839		15,839		15,839			
	Non-Allowable Expenses	71,679		273,071	344,750		344,750	(344,750)	-			
					-		-		-			
					-		-		-			
	TOTAL Other Special Cost Centers	71,679	-	308,552	380,231	-	380,231	(344,750)	35,481			

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	(8,099)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,560)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	468	30		9
10	Interest and Other Investment Income	(3,397)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,718)	43		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	(75)	20		17
18	Fines and Penalties	(56,960)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(182,875)	43		24
25	Fund Raising, Advertising and Promotional	(28,958)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,089)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(85,966)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (380,229)		\$	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)	(151,077)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (151,077)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (531,306)		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	Political Action Committee Payments	\$ (3,949)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Offset Activity Income	(8,396)	11	4
5	Offset Miscellaneous Income	(910)	2	5
6	Offset Miscellaneous Income	(14)	7	6
7	Offset Miscellaneous Income	(541)	21	7
8	Offset Miscellaneous Income	(477)	22	8
9	Disallow Marketing Wages	(71,679)	43	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	(85,966)		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 Page Ownership Listing - 1		None		St Clair Estates	Freeburg	Lessor

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%	\$ 2,127	\$ 2,127	1
2	V	20	Licenses, Dues & Subs		St. Clair Estates	100.00%	55	55	2
3	V	21	Clerical & General Office Exp		St. Clair Estates	100.00%	236	236	3
4	V	30	Depreciation		St. Clair Estates	100.00%	10,416	10,416	4
5	V	34	Rent	174,000	St. Clair Estates	100.00%		(174,000)	5
6	V	43	State Replacement Tax		St. Clair Estates	100.00%	10,089	10,089	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 174,000			\$ 22,923	\$ * (151,077)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS					Ownership Listing-1				
Freeburg Care Center									
ID#		0025098							
Report Period Beginning:		1/1/2025							
Ending:		12/31/2025							
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Operator/Licensee	Building Co.	Management Co./Home Office		
-Owners of companies must be listed instead of company names.									
-Names of trust beneficiaries must be listed.					Ownership Percentage	Ownership Percentage	Ownership Percentage		
First Name	M.I.	Last Name	City	State					
1	John	C	Schauffer	Belleville	IL	20.70000	20.70000		1
2	Herschel	C	Parrish Jr	Belleville	IL	13.75000	13.75000		2
3	Jann	L	Komotos	Webster Groves	MO	2.30000	2.30000		3
4	Jill	A	Connors	Belleville	IL	2.30000	2.30000		4
5	Amy	H	Bouvet	Freeburg	IL	2.30000	2.30000		5
6	Barbara	J	Holland	Mayfield	KY	6.90000	6.90000		6
7	Carolyn	S	Stumpf	Macoutah	IL	6.90000	6.90000		7
8	Brad	A	Towers	Freeburg	IL	6.90000	6.90000		8
9	Nancy	L	Leonard	Madison	CT	3.45000	3.45000		9
10	Charles	W	Borrenpohl	Tetonia	ID	3.45000	3.45000		10
11	Lavonne	NG	Kaiser	Highlands Ranch	CO	3.45000	3.45000		11
12	Amy	VB	Menges	Parker	CO	3.45000	3.45000		12
13	Kathy	L	Lickenbrock	Freeburg	IL	3.45000	3.45000		13
14	Dale	J	Lickenbrock	Freeburg	IL	3.45000	3.45000		14
15	Larry	J	Rhutasel	Freeburg	IL	3.45000	3.45000		15
16	Marjorie	M	Rhutasel	Freeburg	IL	3.45000	3.45000		16
17	Frank	X	Heiligenstein	Freeburg	IL	1.72500	1.72500		17
18	Georgia	J	Heiligenstein	Freeburg	IL	1.72500	1.72500		18
19	Susan	Y	Martin	Millstadt	IL	2.30000	2.30000		19
20	Angela	M	Collins	Springfield	MO	2.30000	2.30000		20
21	Lisa	R	Langstraat	Fort Collins	CO	2.30000	2.30000		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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

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.	12,000	L 19, C3	2
3	Herschel Parrish	Director	Board Member	13.75	None	N/A	N/A	Director Fees	1,200	L 18, C3	3
4	John Schaufler	President	Board Member	20.70	None	N/A	N/A	Director Fees	1,200	L 18, C3	4
5	Larry Rhutasel	Sec/Treasurer	Board Member	3.45	None	N/A	N/A	Director Fees	1,200	L 18, C3	5
6	Frank Heiligenstein	Director	Board Member	3.45	None	N/A	N/A	Director Fees	1,200	L 18, C3	6
7	Dale Lickenbrock	Director	Board Member	3.45	None	N/A	N/A	Director Fees	1,200	L 18, C3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,600		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

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Citizens Community Bank		X	Working Capital	\$4,556.82	3/20/24	100,000	65,000	6/20/26	0.0875	3,891		6
7													7
8													8
9	TOTAL Facility Related				\$4,556.82		\$ 100,000	\$ 65,000			\$ 3,891		9
	B. Non-Facility Related*												
10													10
11								Interest on Insurance Policy			4,462		11
12								Interest Income Offset			(3,397)		12
13													13
14	TOTAL Non-Facility Related						\$				\$ 1,065		14
15	TOTALS (line 9+line14)						\$ 100,000	\$ 65,000			\$ 4,956		15

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

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME	Freeburg Care Center	COUNTY	Saint Clair
---------------	----------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Larry Templin

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:29,405
- B. General Construction Type:ExteriorBrickFrameSteelNumber of Stories1
- C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. List the bed capacity for the building if it differs from the licensed total.
- G. Have you properly capitalized all major repairs and equipment purchases?
- H. Are you presently operating under a sale and leaseback arrangement?

N/A
- I. Are you presently operating under a sublease agreement?
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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

- K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

N/A
2. Number of Years Over Which it is Being Amortized:

N/A
3. Current Period Amortization:

N/A
4. Dates Incurred:

N/A

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Nursing Home	150,000		1979		\$22,480	
2							
3	TOTALS	150,000				\$22,480	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

#

0025098

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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			3,116	6
7				1989	2,110		27			2,110	7
8	10			1998	411,348		39.5	10,416	10,416	296,783	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			4,771	16
17	Parking Lot			1986	2,518		10			2,518	17
18	Driveway			1987	3,990		15			3,990	18
19	Driveway			1989	1,465		15			1,465	19
20	Entry Sign			1990	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

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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		15			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		10			4,621	69
70	TOTAL (lines 4 thru 69)		\$ 2,133,678	\$		\$ 10,416	\$ 10,416	\$ 2,019,760	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:

1/1/2025

Ending:

12/31/2025

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	\$		\$ 10,416	\$ 10,416	\$ 2,019,760	1
2	Sidewalks, Lighting, & Landscaping	2006	16,064		15			16,064	2
3	Parking Lot	2006	6,748		15			6,748	3
4	Replace Parts Of Backflow Preventor	2007	5,801		10			5,801	4
5	Landscape Front Of Building	2007	10,345		10			10,345	5
6	Remove & Replace Old Sidewalks & Parking Lot	2007	29,079		15			29,079	6
7	Canopy Addition	2008	15,191		15			15,191	7
8	Dawn To Dusk Lighting	2008	1,543		10			1,543	8
9	D2 Doors Replaced	2009	3,321		15			3,321	9
10	5 Ton Rooftop Unit	2009	7,217		10			7,217	10
11	Rooftop Repair West Wing	2009	7,375		7			7,375	11
12	Remove And Redesign Nurses Station, New Cabinets, Floor	2010	17,500		10			17,500	12
13	And Countertops								13
14	Repair Kitchen Wall For Damage From Leaking, New Frp	2010	3,000		5			3,000	14
15	Covering And Covebase And Structurally Fixed								15
16	2 Exit Doors And Hardware	2010	2,408	74	15	74		2,408	16
17	Repair To Sprinkler System Due To Leaking And Rusting	2010	3,983		10			3,983	17
18	Replaced Piping And Got System Operational								18
19	52 Doors And Hinges	2010	23,732	793	15	793		23,732	19
20	All Other Doors And Hinges	2011	37,880	2,525	15	2,525		36,613	20
21	Flooring Vct Tile Halls A,b,&c	2011	14,004		10			14,004	21
22	2 Countertops In Kitchen	2011	2,807		10			2,807	22
23	New Part Of Parking Lot	2011	12,000	800	15	800		11,600	23
24	New D Hall Roof	2011	6,995		10			6,995	24
25	Laundry Combustion Air And Ceiling Drywall	2012	13,234		10			13,234	25
26	C-hall Roof Replaced	2012	13,000		10			13,000	26
27	A-hall Roof Replaced	2012	13,225		10			13,225	27
28	Replaced Front Entry Glass	2012	2,055	137	15	137		1,850	28
29	Test On 9 Sprinkler Heads & Replaced	2012	4,360	291	15	291		3,928	29
30	Install Hot Water Heater	2013	8,866		10			8,866	30
31	Replace Dry Sprinkler Pendants	2013	11,500		10			11,500	31
32	Replace Windows In Rooms 1-7	2013	3,137		10			3,137	32
33	Install Air Handler In Janitors Closet	2013	4,540	227	20	227		2,838	33
34	TOTAL (lines 1 thru 33)		\$ 2,434,588	\$ 4,847		\$ 15,263	\$ 10,416	\$ 2,316,664	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:

1/1/2025

Ending:

12/31/2025

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	\$ 4,847		\$ 15,263	\$ 10,416	\$ 2,316,664	1
2	Storage Building	2014	2,540		10	254	254	2,096	2
3	Carpet in Admin Offices	2014	2,742		5			2,742	3
4	B Hall Room Replaced	2014	3,575		10			3,575	4
5	Replaced Ceiling Tile and Lights in Lobby Area	2014	5,562		8			5,562	5
6	Replaced Metal siding on shed	2014	8,850		10			8,850	6
7	Replaced Roof on Shed	2014	2,637		10			2,637	7
8	AC Condensing Unit on D Wing	2014	2,731	59	10	273	214	2,639	8
9	Replace D Hall Flooring Tile	2015	5,327	264	10	264		5,327	9
10	Replaced B Hall Bath Flooring and Fixtures	2015	5,872	150	39	150		2,367	10
11	Landscaping	2015	9,740	649	15	649		8,602	11
12	Install Roam Alert System-Main Entrance	2015	3,412	172	10	172		3,412	12
13	Installed Electricity to Storage Room (see line 3 above)	2015	1,640	164	10	164		1,271	13
14	Repair to Sprinkler System	2015	5,967	296	10	296		5,967	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	3,603	39	3,603		49,623	18
19	Replaced Lighting Throughout Halls/Dining Areas/Nurses Station	2016	19,816	509	39	509		4,772	19
20	Sprinkler system improvements including new compressor	2016	6,210	159	39	159		1,493	20
21	Installed 62 blinds in resident rooms	2016	6,264	626	10	626		5,953	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	135	39	135		1,268	23
24	Installed 43 Privacy Curtains	2016	4,798	480	10	480		4,562	24
25	Signage in Building	2016	2,839	284	10	284		2,699	25
26	Removed and replaced bushes, rock, mulch	2016	3,733	249	15	249		2,386	26
27	Installed New Windows in Resident Rooms	2016	17,997	461	39	461		4,327	27
28	Replaced compressor on roof top A/C unit	2016	2,725	70	39	70		656	28
29	Awnings over serving windows in dining room	2016	6,722	672	10	672		6,389	29
30	Remove and replace vinyl tile in rooms D10-11	2016	2,730	273	10	273		2,595	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	615	39	615		5,768	33
34	TOTAL (lines 1 thru 33)		\$ 2,738,755	\$ 14,737		\$ 25,621	\$ 10,884	\$ 2,464,202	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:

1/1/2025

Ending:

12/31/2025

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 12C, Carried Forward		\$ 2,738,755	\$ 14,737		\$ 25,621	\$ 10,884	\$ 2,464,202	1
2	Installed Wireless Access Point System	2016	4,100		5			4,100	2
3	Entrance Sign by Road	2016	5,800	580	10	580		5,514	3
4	Tile-Care Plan Office/Therapy Office	2017	3,129	313	10	313		2,660	4
5	Parking Lot Expansion	2017	40,201	2,010	20	2,010		17,085	5
6	Roof Repairs	2017	12,394	620	20	620		5,270	6
7	Flooring-Kitchen	2018	10,037	1,003	10	1,003		7,523	7
8	Rooftop A/C Unit	2018	11,487	1,149	10	1,149		8,617	8
9	Install 3 Tankless Water Heaters	2019	22,460	1,497	15	1,497		9,730	9
10	Parking Lot / Sidewalk Repairs	2019	20,992	1,400	15	1,400		9,100	10
11	Repair Parking Lot Drainage	2020	23,085	1,539	15	1,539		8,465	11
12	Bury Pipe-Rear Building	2020	2,750	183	15	183		1,006	12
13	Grade By New Concrete & Install Fabric & Meremac Rock	2021	4,750	317	15	317		1,426	13
14	New Concrete Patio & Sidewalk/Replace Parking Lot Portion	2021	20,525	1,368	15	1,368		6,156	14
15	New Wall Tile & Flooring - Men's Bathroom & Admin Office	2021	10,968	731	15	731		3,290	15
16	Install New Dry Valve on Sprinkler System	2021	7,015	468	15	468		2,106	16
17	New Gazebo	2021	7,341	489	15	489		2,201	17
18	Fire Sprinkler Repair 3 Leaks in D Wing	2021	3,810	254	15	254		1,143	18
19	Fire Sprinkler Repair - Replace Piping	2021	3,239	216	15	216		972	19
20	New Tankless Hot Water Heater	2021	3,119	208	15	208		936	20
21	Replaced Circulating Pump	2022	2,713	181	15	181		633	21
22	Install New Water Heater	2022	3,181	212	15	212		742	22
23	New Flooring - Dining Rm, A/B/C/D Halls & Nurses Stations	2022	32,870	2,191	15	2,191		7,669	23
24	New Piping from Cold water Supply to Water Heater/Softener	2022	4,287	286	15	286		1,001	24
25	Hydraulic Flush of Dry Sprinkler System	2022	3,970	265	15	265		927	25
26	Coat Flat Area of Roof over Dining Room	2022	5,100	340	15	340		1,190	26
27	Installed New 5-Ton Roof Top Unit with Disconnect Switch	2022	12,473	831	15	831		2,909	27
28	Replace Roof on Carport	2023	3,623	242	15	242		605	28
29	Replace Flooring - Shower Rm / B Hall / Kitchen	2023	20,727	1,381	15	1,381		3,453	29
30	Repair 6 Inch Water Main in Front of Building	2023	4,813	321	15	321		802	30
31	Install New Phone System	2023	14,138	943	15	943		2,357	31
32	Install New Air Filtration System	2023	8,475	565	15	565		1,413	32
33	Remove Trees and Grind Stumps	2023	11,557	770	15	770		1,925	33
34	TOTAL (lines 1 thru 33)		\$ 3,083,884	\$ 37,610		\$ 48,494	\$ 10,884	\$ 2,587,128	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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 12D, Carried Forward		\$ 3,083,884	\$ 37,610		\$ 48,494	\$ 10,884	\$ 2,587,128	1
2	New Tankless Water Heater	2024	19,915	1,328	15	1,328		1,992	2
3	New Flooring - Residents Rooms D Hall	2024	11,743	783	15	783		1,174	3
4	Replace Walk In Cooler Condenser	2024	5,301	353	15	353		530	4
5	Installed 80 Gallon Storage Tank	2024	3,340	223	15	223		334	5
6	Install Handheld Shower Faucets in 3 Showers	2024	2,550	170	15	170		255	6
7	Install 5-ton HVAC System Rooftop Unit	2025	10,970	365	15	365		365	7
8	Install New Flooring - Resident Rooms and Nurses Station	2025	15,421	514	15	514		514	8
9	Install Rinnnai Tankless Water Heater - Hallway Closet	2025	4,395	147	15	147		147	9
10	Fire Sprinkler Repairs in Laundry Rm/Replace Tamper Switch	2025	11,213	374	15	374		374	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)		\$ 3,168,732	\$ 41,867		\$ 52,751	\$ 10,884	\$ 2,592,813	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	\$ 270,970	\$ 18,485	\$ 18,485	\$	5-15 Yrs	\$ 151,578	71
72	Current Year Purchases	11,731	765	765		5-10 yrs	765	72
73	Fully Depreciated Assets	482,820					482,820	73
74	From St Clair Estates	187,737					187,737	74
75	TOTALS	\$ 953,258	\$ 19,250	\$ 19,250	\$		\$ 822,900	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	Resident	2019 Ford E-350 Diamond Coach	2020	\$ 69,518	\$ 6,950	\$ 6,950	\$	5	\$ 69,518	76
77										77
78										78
79										79
80	TOTALS			\$ 69,518	\$ 6,950	\$ 6,950	\$		\$ 69,518	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)	\$ 4,213,988	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,067	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 78,951	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,884	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,485,231	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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: 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: N/A *

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: \$ 54,240 Description: See Attached 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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Freeburg Care Center

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Therapy Equipment	17,127
Laundry Equipment	15,179
Dish Machine	3,003
Office Equipment	2,560
Medical Equipment	13,602
Storage	840
Miscellaneous	1,929
Total - Line 16	54,240

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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.
- 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	39(3)	hrs	\$	6,692	\$ 243,459	\$	6,692	\$ 243,459	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,686	134,446		2,686	134,446	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		8,732	292,476	1,090	8,732	293,566	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				211,527		211,527	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	18,110	\$ 670,381	\$ 212,617	18,110	\$ 882,998	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 4,323	\$ 55,083	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,104,357	1,105,347	3
4	Supply Inventory (priced at Cost)	3,000	3,000	4
5	Short-Term Investments			5
6	Prepaid Insurance	49,357	49,357	6
7	Other Prepaid Expenses	2,267	2,267	7
8	Accounts Receivable (owners or related parties)	79,524		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,242,828	\$ 1,215,054	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		22,480	13
14	Buildings, at Historical Cost	102,162	1,818,679	14
15	Leasehold Improvements, at Historical Cost	1,108,474	1,350,053	15
16	Equipment, at Historical Cost	843,602	1,022,776	16
17	Accumulated Depreciation (book methods)	(1,523,510)	(3,485,231)	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)	\$ 530,728	\$ 728,757	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,773,556	\$ 1,943,811	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 646,085	\$ 646,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,511	91,511	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,085	8,085	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,900	65,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	85,621	85,621	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 897,202	\$ 897,202	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	65,000	65,000	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)	\$ 65,000	\$ 65,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 962,202	\$ 962,202	46
47	TOTAL EQUITY(page 18, line 24)	\$ 811,354	\$ 981,609	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,773,556	\$ 1,943,811	48

Freeburg Care Center

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities

	Operating	After Consolidation
Insurance	37,773	37,773
401K Liability	3,170	3,170
Accr Lic Bed Tax	44,678	44,678
TOTAL Line 36	85,621	85,621

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 537,617	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 537,617	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	273,737	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)	\$ 273,737	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)	\$ 811,354	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 7,237,727	1
2	Discounts and Allowances for all Levels	2,804,563	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,042,290	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	260,514	6
7	Oxygen	400	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 260,914	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	18,238	13
14	Non-Patient Meals	8,099	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,414	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	436	19
20	Radiology and X-Ray		20
21	Other Medical Services	88,060	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 117,247	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,397	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,397	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	1,942	28
28a	Activity Income	8,396	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,338	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,434,186	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,926,558	31
32	Health Care	4,507,359	32
33	General Administration	1,548,290	33
	B. Capital Expense		
34	Ownership	370,520	34
	C. Ancillary Expense		
35	Special Cost Centers	1,283,486	35
36	Provider Participation Fee	524,236	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,160,449	40
41	Income before Income Taxes (line 30 minus line 40)**	273,737	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 273,737	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 581,788	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,398,021	45
46	MMAI-Medicaid is the Primary Payer	42,663	46
47	MMAI-Medicare is the Primary Payer	4,232	47
48	Private Pay	3,631,800	48
49	Medicare Part A	3,907,123	49
50	Other-(specify) Medicare Advantage/Insurance	476,663	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,042,290	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,318	1,524	\$ 94,146	\$ 61.78	1
2	Assistant Director of Nursing	2,526	2,632	108,902	41.38	2
3	Registered Nurses	7,772	8,469	362,781	42.84	3
4	Licensed Practical Nurses	26,235	27,818	972,773	34.97	4
5	CNAs & Orderlies	65,267	69,158	1,606,441	23.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,385	17,173	284,264	16.55	10
11	Social Service Workers	3,688	3,935	103,262	26.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,959	29,676	503,419	16.96	15
16	Dishwashers					16
17	Maintenance Workers	3,441	3,715	84,376	22.71	17
18	Housekeepers	18,414	19,320	322,941	16.72	18
19	Laundry	8,049	8,620	142,272	16.50	19
20	Administrator	1,883	2,080	130,457	62.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,243	10,188	234,915	23.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Ward Clerk	1,789	2,027	51,675	25.49	32
33	Other(specify) Marketing	1,703	1,928	71,679	37.18	33
34	TOTAL (lines 1 - 33)	195,672	208,263	\$ 5,074,303 *	\$ 24.36	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	Monthly	\$ 15,874	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	Quarterly	1,023	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,507	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,040	L11, C3	44
45	Social Service Consultant	Monthly	600	L12, C3	45
46	Other(specify) MDS Consultant	Monthly	728	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,772		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	1,033	61,990	L10, C3	51
52	Certified Nurse Assistants/Aides	18,862	693,014	L10, C3	52
53	TOTAL (lines 50 - 52)	19,895	\$ 755,004		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number		Freeburg Care Center		STATE OF ILLINOIS		# 0025098		Report Period Beginning:		1/1/2025		Page 21		Ending: 12/31/2025	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		Ownership		Description		Amount		Description		Amount			
Amy Bonta		Administrator		0		Workers' Compensation Insurance		\$ 66,310		IDPH License Fee		\$ 1,990			
						Unemployment Compensation Insurance		28,187		Advertising: Employee Recruitment					
						FICA Taxes		376,368		Health Care Worker Background Check					
						Employee Health Insurance		209,721		(Indicate # of checks performed)		1,711			
						Employee Meals				Patient Background Checks		2,447			
						Illinois Municipal Retirement Fund (IMRF)*				Association Dues (total from pg 22, #4)		11,138			
						401k		10,492							
						Other Employee Benefits		35,755		Miscellaneous Dues & Subscriptions		2,525			
										From St Clair Estates		55			
										Less: Public Relations Expense		(75)			
										PAC and Lobbying payments		(3,949)			
										All non-allowable advertising		()			
TOTAL (agree to Schedule V, line 17, col. 1)										TOTAL (agree to Sch. V,		\$ 15,842			
(List each licensed administrator separately.)								\$ 726,833		line 20, col. 8)					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Description		Amount		Description		Line #		Amount		Description		Amount			
N/A		\$						\$		Out-of-State Travel		\$			
										In-State Travel					
TOTAL (agree to Schedule V, line 17, col. 3)		\$								Seminar Expense		2,884			
(Attach a copy of any management service agreement)															
C. Professional Services															
Vendor/Payee		Type		Amount											
Boyce, Hund & Associates		Accounting		\$ 2,400											
Templin Healthcare Accounting Svc		Accounting		17,209											
John Schaulfer		Administrative Consultant		12,000											
Larry Rhutasel		Administrative Consultant		9,600											
Mediprocity		Computer Services		1,800											
Point Click Care		Data Processing		28,660											
SNFQAPI, LLC		Compliance Consulting		4,620											
Wellsky		Data Processing		4,770											
Inovalon		Data Processing		4,737											
Linda Wardlow		Billing Consultant		43,232											
ADP		Payroll Processing		39,816											
										Entertainment Expense		()			
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL		\$		(agree to Sch. V,					
(For legal fee disclosure, see page 39 of instructions)				\$ 168,844						line 24, col. 8)		\$ 2,884			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	7,189
	7,189
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	3,949
	3,949
	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	11,138
	11,138
	Total
- (5)

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

\$	7,298	Line	10
----	-------	------	----
- (6)

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

Yes

If NO, attach a complete explanation.
- (7)

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

\$	524,236
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

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

\$		Has any meal income been offset against related costs?	Yes	Indicate the amount.	\$	8,099
----	--	---	-----	----------------------	----	-------
- (12)

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?

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

\$

N/A

No
- (13)

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

Firm Name:

N/A

No
- (14)

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

Yes
- (15)

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.