FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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 (Number) FREEBURG (City) 62243 (Zip Code)

County: ST. CLAIR

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

HFS ID Number: 371062186001

Date of Initial License for Current Owners: 03/14/79

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY
JAMESTOWN MANAGEMENT
Telephone Number: (618) 549-8331
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 01/01/2010 to 12/31/2010 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) ROGER W. BAGLEY

(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) 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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		10,687	1,460	12,147	8
9	SNF/PED					9
10	ICF	18,282	3,441		21,723	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,282	14,128	1,460	33,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.64%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/16/79

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/16/79 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,460

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: _____

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

Facility Name & ID Numbe FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	157,481	9,093	8,333	174,907		174,907		174,907			1
2	Food Purchase		139,542		139,542	3,144	142,686	(568)	142,118			2
3	Housekeeping	109,381	13,291		122,672		122,672		122,672			3
4	Laundry	60,166	11,334		71,500		71,500		71,500			4
5	Heat and Other Utilities			110,728	110,728		110,728		110,728			5
6	Maintenance	35,679	24,166	36,552	96,397		96,397		96,397			6
7	Other (specify):*											7
8	**TOTAL General Services**	362,707	197,426	155,613	715,746	3,144	718,890	(568)	718,322			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,269,874	39,237	396,266	1,705,377	(3,144)	1,702,233		1,702,233			10
10a	Therapy			2,446	2,446		2,446		2,446			10a
11	Activities	39,476	3,560	1,571	44,607		44,607		44,607			11
12	Social Services	30,474		1,572	32,046		32,046		32,046			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,339,824	42,797	405,455	1,788,076	(3,144)	1,784,932		1,784,932			16
	C. General Administration											
17	Administrative	88,088		8,400	96,488		96,488		96,488			17
18	Directors Fees			2,800	2,800		2,800		2,800			18
19	Professional Services			143,834	143,834		143,834		143,834			19
20	Dues, Fees, Subscriptions & Promotions			17,134	17,134		17,134	(2,634)	14,500			20
21	Clerical & General Office Expenses	60,776	10,991	6,356	78,123		78,123	(345)	77,778			21
22	Employee Benefits & Payroll Taxes			240,004	240,004		240,004		240,004			22
23	Inservice Training & Education			436	436		436		436			23
24	Travel and Seminar			4,812	4,812		4,812		4,812			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,049	75,049		75,049		75,049			26
27	Other (specify):*											27
28	**TOTAL General Administration**	148,864	10,991	498,825	658,680		658,680	(2,979)	655,701			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,851,395	251,214	1,059,893	3,162,502		3,162,502	(3,547)	3,158,955			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100**

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

Facility Name & ID Numbe FREEBURG CARE CENTER #0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,465	55,465		55,465	1,849	57,314			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,525	9,525		9,525	(9,525)				32
33	Real Estate Taxes			42,331	42,331		42,331		42,331			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			1,254	1,254		1,254		1,254			35
36	Other (specify):*											36
37	**TOTAL Ownership**			252,575	252,575		252,575	(151,676)	100,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,142	114,155	193,297		193,297		193,297			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		79,142	178,760	257,902		257,902		257,902			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,851,395	330,356	1,491,228	3,672,979		3,672,979	(155,223)	3,517,756			45

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

Facility Name & ID Numbe FREEBURG CARE CENTER # 0025098 Report Period Beginning 01/01/2010 Ending: 12/31/2010

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 In column 2 below, reference the line on which the particular cost was included. (See instruction

	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 Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciatior	(16,725)	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(568)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20)	21		18
19	Entertainment				19
20	Contributions	(325)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,584)	20		28
29	Other-Attach Schedule	(9,575)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (29,797)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th 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 Organizatior Costs (Schedule VII)	(125,426)	SCH VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (125,426)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (155,223)		37

*These costs are only allowable if they are necessary to meet minimu licensing standards. Attach a schedule detailing the items include on these lines.

C. Are the following expenses included in Sections A to D of pages and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassificatio (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS

FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 PAGE 5	$		1
2				2
3	CHAMBER OF COMMERCE DUES	(50)	20	3
4	INTEREST PAID TO OWNERS ON LOAN	(9,525)	32	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,575)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(568)	0	0	0	0	0	0	0	0	0	0	(568)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(568)	0	0	0	0	0	0	0	0	0	0	(568)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,634)	0	0	0	0	0	0	0	0	0	0	(2,634)	20
21	Clerical & General Office Expenses	(345)	0	0	0	0	0	0	0	0	0	0	(345)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,979)	0	0	0	0	0	0	0	0	0	0	(2,979)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,547)	0	0	0	0	0	0	0	0	0	0	(3,547)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,725)	18,574	0	0	0	0	0	0	0	0	0	1,849	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,525)	0	0	0	0	0	0	0	0	0	0	(9,525)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(144,000)	0	0	0	0	0	0	0	0	0	(144,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,250)	(125,426)	0	0	0	0	0	0	0	0	0	(151,676)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,797)	(125,426)	0	0	0	0	0	0	0	0	0	(155,223)	45

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE OWNER'S LIST ATTACHED				ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
				LAND TRUST		RENTAL

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 144,000	ST. CLAIR ESTATES	100.00%	$	$ (144,000)	1
2	V	30	DEPRECIATION		ST. CLAIR ESTATES	100.00%	18,574	18,574	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 144,000			$ 18,574	$ * (125,426)	14

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	LARRY RHUTASEL	CONSULTANT	ADM. CONSUL	6.90	NONE	2	5.00	ADM CONS	$ 5,400	17/3	1
2	JOHN SCHAUFLER	CONSULTANT	ADM. CONSUL	20.70	NONE	2	5.00	ADM CONS	3,000	17/3	2
3	DALE TOWERS	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	400	18/3	3
4	JOHN SCHAUFLER	DIRECTOR	board member	20.70	NONE	N/A	N/A	director fees	600	18/3	4
5	LARRY RHUTASEL	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	600	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	board member	3.44	NONE	N/A	N/A	director fees	600	18/3	6
7	CAROLYN STUMPF	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	600	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,200		13

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

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X]

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

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

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

Facility Name & ID Numbe FREEBURG CARE CENTER # 0025098 Report Period Beginning 01/01/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 40,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 40,831	2
3. Under or (over) accrual (line 2 minus line 1).		$ 831	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru (		$ 42,331	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	40,217	8
	2006	38,304	9
	2007	36,880	10
	2008	39,420	11
	2009	40,831	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual (taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of a application for real estate tax exemption unless the building is rented from a for-profit enti**

This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FREEBURG CARE CENTER COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0025098

CONTACT PERSON REGARDING THIS REPORT ROGER BAGLEY

TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-29.0-400-040	LOT/SEC-29-SUBL/TWP-1S-BLK	$ 40,787.72	$ 40,787.72
2.	14-29.0-400-038	LOT/SEC29-SUBL/TWP-1S-BLK	$ 43.16	$ 43.16
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,830.88	$ 40,830.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provid copies of their original **second installment** tax bill.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] (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. 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: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1979	1979	$ 1,174,206	$	30	$	$	$ 1,174,206	4
5	10		1985	1985	227,899		30	7,597	7,597	193,723	5
6			1985	1986	3,116		30	104	104	2,548	6
7			1989	1989	2,110		27	78	78	1,716	7
8	10		1998	1997	411,348		39.5	10,415	10,415	140,551	8
	Improvement Type**										
9	PARKING LOT TITLE INSURANCE			1981	7,109		30	221	221	7,074	9
10	SIDEWALK			1983	908		20			908	10
11	LAUNDRY RENOVATION			1983	3,303		25			3,303	11
12	STORAGE BUILDING			1983	6,690		20			6,690	12
13	WINDOW REPLACEMENT			1983	967		30	32	32	880	13
14	KITCHEN RENOVATIONS			1983	734		25			734	14
15	VENTILATION SYSTEM / ISULATION			1984	1,132		10			1,132	15
16	CONCRETE PAVING			1985	4,124		20			4,124	16
17	PARKING LOT			1986	2,518		10			2,518	17
18	STORAGE SHED			1987	10,213		15			10,213	18
19	DRIVEWAY			1988	3,990		15			3,990	19
20	DRIVEWAY			1989	1,465		15			1,465	20
21	ENTRY SIGN			1990	2,890		15			2,890	21
22	PARKING LOT			1990	11,951		20	290	290	11,951	22
23	SEWER			1990	17,548		25	702	702	14,391	23
24	LIGHTS			1990	1,140		10			1,140	24
25	HEAT PUMPS / COMPRESSOR			1990	2,527		8			2,527	25
26	SEWER REPAIRS / DRIVEWAY REPAIRS / PLUMBING			1991	4,471		15			4,471	26
27	ROOFTOP AIR CONDITIONER			1991	4,600		8			4,600	27
28	FRONT OFFICE REMODELING / DRIVEWAY REPAIRS			1992	10,838		15			10,838	28
29	CARPET			1992	14,036		5			14,036	29
30	PARKING LOT & DRIVEWAY			1993	14,900		15			14,900	30
31	FENCE / PARKING LOT & DRIVEWAY			1994	6,672		15			6,672	31
32	CEILING TILE			1994	1,310		5			1,310	32
33	LANDSCAPING			1996	1,499		10			1,499	33
34	WATER HEATER			1996	3,426	228	15	228		3,306	34
35	5 TON CONDENSING UNIT			1996	1,195		10			1,195	35
36	WATER LINE & GAS LINE FOR ADDITION			1997	633		10			633	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	AIR COMPRESSOR FOR FIRE SYSTEM	1997	$ 1,244	$ 83	10	$	$ (83)	$ 1,244	37
38	CERAMIC TILE & LABOR FOR SHOWERS	1997	5,795	386	10	386		5,211	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	285	5	285		3,847	40
41	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM	1997	503		15			503	41
42	TELEPHONE SYSTEM	1997	4,640		10			4,640	42
43	8 G E HEAT / COOL UNITS	1997	7,624		10			7,624	43
44	cabinets, countertops, & labor for new nurses station and	1998	6,073	405	15	405		5,062	44
45	gutting old								45
46	expanded care plan office adding coutertop & windows	1998	6,952	463	15	463		5,788	46
47	FIRE ALARM	1998	4,431	295	15	295		3,688	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		2,437	48
49	PHONE JACKS INSTALLED	1998	777	52	15	52		650	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10			3,884	50
51	replaced ceiling tile & constructed new storage cabinets in	1999	4,951		10			4,951	51
52	activity room								52
53	ROOF TOP FAN	1999	866	58	15	58		667	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		2,599	54
55	NEW ROOF ON WINGS A,B, & C	1999	16,397		10			16,397	55
56	WALLPAPER IN DINING ROOM	2000	1,255		5			1,255	56
57	gutted bathroom installed windows & worktop to convert to	2000	2,374	122	10	122		2,374	57
58	DON office								58
59	finish DON office - mudd, sand, and paint room, set cabinets	2001	2,194	219	10	219		2,081	59
60	& build shelves. Put carpet & cove base down & handrail up								60
61	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		1,111	61
62	remove old shower on d-hall and put in new shower walls	2001	2,097	210	10	210		1,995	62
63	and mudd, sand, and paint to seal plaster around shower								63
64	tear out wall between secretary and bookkeeper office	2003	6,638	664	10	664		4,980	64
65	and build countertops and workspace, new carpet, paint, etc.								65
66	BUILD UP ROOF SECTION	2004	8,072	807	10	807		5,246	66
67	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	6,638	6,638	36,509	67
68	firewall laundry room, fire ducts & ceiling tiles in oxygen room	2005	7,588	759	10	759		4,174	68
69	replace smoke detectors	2005	4,457	446	10	446		2,453	69
70	TOTAL (lines 4 thru 69)		$ 2,139,270	$ 6,020		$ 32,014	$ 25,994	$ 1,784,006	70

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,139,270	$ 6,020		$ 32,014	$ 25,994	$ 1,784,006	1
2	5 TON AIR CONDITIONER	2006	4,621	462	10	462		2,079	2
3	SIDEWALKS, LIGHTING, & LANDSCAPING	2006	16,064		15	1,071	1,071	4,819	3
4	PARKING LOT	2006	6,748		15	450	450	2,025	4
5	REPLACE PARTS OF BACKFLOW PREVENTOR	2007	5,801	580	10	580		2,030	5
6	LANDSCAPE FRONT OF BUILDING	2007	10,345	1,035	10	1,035		3,622	6
7	REMOVE & REPLACE OLD SIDEWALKS & PARKING LOT	2007	29,079	1,939	15	1,939		6,786	7
8	CANOPY ADDITION	2008	15,191	1,013	15	1,013		2,532	8
9	DAWN TO DUSK LIGHTING	2008	1,543	154	10	154		385	9
10	2 DOORS REPLACED	2009	3,321	221	15	221		332	10
11	5 TON ROOFTOP UNIT	2009	7,217	722	10	722		1,083	11
12	ROOFTOP REPAIR WEST WING	2009	7,375	1,054	7	1,054		1,581	12
13	remove and redesign nurses station, new cabinets, floor	2010	17,500	875	10	875		875	13
14	and countertops								14
15	repair kitchen wall are for damage from leaking, new FRP	2010	3,000	300	5	300		300	15
16	covering and covebase, once structurally fixed								16
17	2 EXIT DOORS AND HARDWARE	2010	2,408	80	15	80		80	17
18	repair to sprinkler system due to leaking and rusting	2010	3,983	199	10	199		199	18
19	replaced piping and got system operational								19
20	52 DOORS AND HINGES	2010	23,732	791	15	791		791	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)		$ 2,297,198	$ 15,445		$ 42,960	$ 27,515	$ 1,813,525	34

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 123,912	$ 1,477	$ 12,642	$ 11,165	various	$ 82,114	71
72	Current Year Purchases	38,543	38,543	1,712	(36,831)	various	1,712	72
73	Fully Depreciated Assets	450,041				various	450,041	73
74								74
75	TOTALS	$ 612,496	$ 40,020	$ 14,354	$ (25,666)		$ 533,867	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,932,174	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,465	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,314	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,849	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,347,392	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 1,254 Description: PRESSURE PAD (450) BI-PAP MACHINE(84) AIR MATTRESS(600) WOUND PUMP (120)
    (Attach a schedule detailing the breakdown of movable equipment.)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
   [X] NO

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

   we only hire trained aides

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.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3; 39/2	hrs	$	598	$ 40,987	$ 150	598	$ 41,137	1
2	Licensed Speech and Language Development Therapist	39/3; 39/2	hrs		160	12,608	19	160	12,627	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3; 39/2	hrs		671	51,544	325	671	51,869	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				54,261		54,261	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	oxygen, tubefeeding, med supplies, iv's Other (specify): lab, xray, other ancil	39/2 39/3				9,016	24,387		33,403	13
14	TOTAL			$	1,429	$ 114,155	$ 79,142	1,429	$ 193,297	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed o
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be liste
on this schedule.

STATE OF ILLINOIS

Facility Name & ID Numbe: FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund

As of 12/31/2010 (last day of reporting year)

This report must be completed even if financial statements are attache

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 181,455	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	396,402		3
4	Supply Inventory (priced at)	3,055		4
5	Short-Term Investments	521,132		5
6	Prepaid Insurance	19,927		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,121,971	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	327,369		15
16	Equipment, at Historical Cost	445,053		16
17	Accumulated Depreciation (book methods	(643,682)		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)**	$ 128,740	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,250,711	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,238	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	290,000		29
30	Accrued Salaries Payable	59,261		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,284		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	11,210		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 530,493	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify)			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 530,493	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 720,218	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,250,711	$	48

*(See instructions.)

Facility Name & ID Numbe FREEBURG CARE CENTER # 0025098 Report Period Beginning 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 562,849	1	
2	Restatements (describe)		2	
3	**2009 ILLINOIS TAXES PAID**	(4,135)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 558,714	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43	405,104	7	
8	Aquisitions of Pooled Companie		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purpose		12	
13	Dividends Paid or Other Distributions to Owner	(243,600)	13	
14	Donated Property, Plant, and Equipmen		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 161,504	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)**	$ 720,218	24	*

*** This must agree with page 17, line 47**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All requir classifications of revenue and expense must be provided on this form, even if financial statements are attach

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 3,752,373	1
2	Discounts and Allowances for all Level	85,796	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2**	$ 3,838,169	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	207,214	6
7	Oxygen	22,681	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7**	$ 229,895	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radi		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,257	19
20	Radiology and X-Ray	2,375	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 6,632	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	3,387	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25**	$ 3,387	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,078,083	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	715,746	31
32	Health Care	1,788,076	32
33	General Administratior	658,680	33
	B. Capital Expense		
34	Ownership	252,575	34
	C. Ancillary Expense		
35	Special Cost Centers	193,297	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,672,979	40
41	**Income before Income Taxes (line 30 minus line 40)***	405,104	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 405,104	43

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

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

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

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,106	3,450	$ 83,878	$ 24.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,265	2,282	51,732	22.67	3
4	Licensed Practical Nurses	21,340	22,431	405,270	18.07	4
5	CNAs & Orderlies	54,471	57,853	697,248	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,263	3,490	39,476	11.31	9
10	Activity Assistants					10
11	Social Service Workers	2,091	2,176	30,474	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,925	2,061	26,907	13.06	14
15	Cook Helpers/Assistants	13,053	13,839	130,574	9.44	15
16	Dishwashers					16
17	Maintenance Workers	2,584	2,745	35,679	13.00	17
18	Housekeepers	10,972	11,434	109,381	9.57	18
19	Laundry	6,252	6,585	60,166	9.14	19
20	Administrator	1,856	2,080	88,088	42.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,710	4,138	60,776	14.69	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	2,042	2,226	31,746	14.26	33
34	TOTAL (lines 1 - 33)	128,930	136,790	$ 1,851,395 *	$ 13.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	169	$ 8,333	1/3	35
36	Medical Director		3,600	9/3	36
37	Medical Records Consultant	20	900	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,208	10/3	39
40	Physical Therapy Consultant	33	2,062	10A/3	40
41	Occupational Therapy Consultant	1	70	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	314	10A/3	43
44	Activity Consultant	22	1,571	11/3	44
45	Social Service Consultant	22	1,572	12/3	45
46	Other(specify) ADMINISTRATIVE		8,400	17/3	46
47	BILLING CONSULTANT		594	19/3	47
48					48
49	TOTAL (lines 35 - 48)	272	$ 30,624		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	3,779	124,382	10/3	51
52	Certified Nurse Assistants/Aides	13,648	267,776	10/3	52
53	TOTAL (lines 50 - 52)	17,427	$ 392,158		53

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN HUELSKAMP	ADMINISTRATOR	0	$ 88,088
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,088

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANTS	$ 8,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 8,400

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MANAGEMENT	MANAGEMENT	$ 142,338
RICHARD BRESLIN	TAX RETURN PREP	875
THOMAS LECHIEN	LEGAL FEES	27
INNOVATIVE SOLUTIONS	BILLING CONSULTANT	594
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 143,834

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,801
Unemployment Compensation Insurance	13,738
FICA Taxes	141,632
Employee Health Insurance	8,896
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSES	12,458
VACCINES	1,011
EMPLOYEE PARTIES, AWARDS, GIFTS, ETC	8,468
TOTAL (agree to Schedule V, line 22, col.8)	$ 240,004

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 994
Advertising: Employee Recruitment	7,145
Health Care Worker Background Check	
(Indicate # of checks performed 74)	1,075
Patient Background Checks 90	1,610
other adv (2584) chamber of comm(50)	2,634
subscr(500) corp fee(100) bus lic(30)	630
allscript sub (2231) sams(70)INHAA(100)	2,401
kit health inspec(350) elim chamber(50)	300
clia(150)notary(45)pioneer(50)IAPA(50)	295
Less: Public Relations Expense	( )
Non-allowable advertising	(2,584)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,500

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,686
Seminar Expense	3,126
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,812

**See instructions.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2005	$ 1,942	3	$ 647	$ 324	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,942		$ 647	$ 324	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost report **NO**
If YES, give association name and amount **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this period **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of lease

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo 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 ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **64,605**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie 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 fo 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 function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **NONE** Has any meal income been offset agains related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm **NO**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

FREEBURG CARE CENTER
SCHEDULE OF RECLASSIFICATIONS FOR PGS 3&4 COL #5
12/31/2010
ID#0025098

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	3144	
10	MEDICAL SUPPLIES		3144
	RECL FOOD SUPPLEMENTS		