

		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.

<p><b>I. IDPH License ID Number:</b> <u>0049155</u></p> <p><b>Facility Name:</b> <u>Freeport Rehab &amp; Health</u></p> <p><b>Address:</b> <u>900 S. Kiwanis Dr.</u> <u>Freeport</u> <u>61032</u>        Number City Zip Code</p> <p><b>County:</b> <u>Stephenson</u></p> <p><b>Telephone Number:</b> <u>(815) 235-6196</u> Fax # <u>(815) 235-5365</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/08</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td>  <input checked="" type="checkbox"/> Charitable Corp.</td> <td>  <input type="checkbox"/> Individual</td> <td>  <input type="checkbox"/> State</td> </tr> <tr> <td>  <input type="checkbox"/> Trust</td> <td>  <input type="checkbox"/> Partnership</td> <td>  <input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 (C) 3</u></td> <td>  <input type="checkbox"/> Corporation</td> <td>  <input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td>  <input type="checkbox"/> "Sub-S" Corp.</td> <td>  <input type="checkbox"/> Limited Liability Co. _____</td> </tr> <tr> <td></td> <td>  <input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td>  <input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (C) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. _____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/2009</u> to <u>03/31/2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Darcee Fanning</u></td> </tr> <tr> <td>(Title) <u>Regional Director</u></td> </tr> <tr> <td rowspan="5" style="width: 15%; vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) <u>See Attached Independent Accountant's Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u> <u>117 E Main Street, Suite 210</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u></td> </tr> <tr> <td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Darcee Fanning</u>	(Title) <u>Regional Director</u>	<b>Paid Preparer</b>	(Signed) <u>See Attached Independent Accountant's Report</u>	(Date) _____	(Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u> <u>117 E Main Street, Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
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Facility Name & ID Number Freeport Rehab & Health

# 0049155 Report Period Beginning: 04/01/2009 Ending: 03/31/2010

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	48,910	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	18,117	9,902	7,053	35,072	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	18,117	9,902	7,053	35,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.71%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/2008

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/2008 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 134 and days of care provided 6,739

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 3/31/10 Fiscal Year: 3/31/10

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 04/01/2009 Ending: 03/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	237,886	28,261	8,216	274,363		274,363		274,363		1
2	Food Purchase		208,258		208,258		208,258		208,258		2
3	Housekeeping	96,180	31,252	66	127,498		127,498		127,498		3
4	Laundry	44,111	12,040		56,151		56,151		56,151		4
5	Heat and Other Utilities			127,729	127,729		127,729		127,729		5
6	Maintenance	59,088	25,209	48,025	132,322		132,322		132,322		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	437,265	305,020	184,036	926,321		926,321		926,321		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,081	13,081		13,081		13,081		9
10	Nursing and Medical Records	1,467,853	348,277	4,019	1,820,149		1,820,149		1,820,149		10
10a	Therapy			315,880	315,880		315,880		315,880		10a
11	Activities	80,936	590		81,526		81,526	6,352	87,878		11
12	Social Services	27,178			27,178		27,178		27,178		12
13	CNA Training										13
14	Program Transportation			601	601	548	1,149		1,149		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,575,967	348,867	333,581	2,258,415	548	2,258,963	6,352	2,265,315		16
	<b>C. General Administration</b>										
17	Administrative	72,908			72,908		72,908		72,908		17
18	Directors Fees							3,653	3,653		18
19	Professional Services			351,317	351,317		351,317	1,590	352,907		19
20	Dues, Fees, Subscriptions & Promotions			33,412	33,412		33,412	(20,414)	12,998		20
21	Clerical & General Office Expenses	72,168	17,519	29,731	119,418		119,418		119,418		21
22	Employee Benefits & Payroll Taxes			413,195	413,195		413,195		413,195		22
23	Inservice Training & Education			1,325	1,325		1,325		1,325		23
24	Travel and Seminar			480	480		480		480		24
25	Other Admin. Staff Transportation			1,096	1,096	(548)	548		548		25
26	Insurance-Prop.Liab.Malpractice			90,837	90,837		90,837	3,085	93,922		26
27	Other (specify):* <u>See Att Sch V</u>			53,491	53,491		53,491	(53,491)			27
28	<b>TOTAL General Administration</b>	145,076	17,519	974,884	1,137,479	(548)	1,136,931	(65,577)	1,071,354		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,158,308	671,406	1,492,501	4,322,215		4,322,215	(59,225)	4,262,990		29

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

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

Facility Name &amp; ID Number

Freeport Rehab &amp; Health

#0049155

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			275,949	275,949		275,949	(750)	275,199			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			240,239	240,239		240,239	(3,288)	236,951			32
33	Real Estate Taxes			84,413	84,413		84,413		84,413			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,391	1,391		1,391		1,391			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			601,992	601,992		601,992	(4,038)	597,954			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			78,293	78,293		78,293		78,293			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,158,308	671,406	2,172,786	5,002,500		5,002,500	(63,263)	4,939,237			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(5,021)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,146)	V-27		24
25	Fund Raising, Advertising and Promotional	(20,468)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(4,990)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (81,625)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule See Att Sch III	12,010		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 12,010		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (69,615)		37

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

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

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

BHF USE ONLY							
48		49		50		51	52

Freeport Rehab & Health

ID# 0049155

Report Period Beginning: 04/01/2009

Ending: 03/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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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	<b>Total</b>	0	49







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
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	See Attached Schedule I		See Attached Schedule I		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	LTC Support Services, LLC		\$	\$	1
2	V			See Attached Independent Accountant's Report				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		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Freeport Rehab &amp; Health

# 0049155

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

## 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 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	See Attached Schedule III								\$ 3,653	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,653		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 Freeport Rehab & Health

# 0049155

Report Period Beginning:

04/01/2009

Ending: 3/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Residential Alternatives of Illinois, Inc.

Street Address 285 S. Farnham

City / State / Zip Code Galesburg, IL 61401

Phone Number ( 309) 343-1550

Fax Number ( 309) 343-2857

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.

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	See Attached Schedule II & III				\$	\$		\$ 12,010	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				\$	\$		\$ 12,010	25

Facility Name & ID Number

Freeport Rehab & Health

# 0049155

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Frances House, Inc.	X		Facility Purchase	\$25,918.73	01/31/08	\$ 4,022,766	\$ 3,862,017	02/28/2033	6.0000	\$ 240,239	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Home office allocation adj	X									1,733	6							
7	Less Interest Income		X	from page 5, line 10							(5,021)	7							
8												8							
9	<b>TOTAL Facility Related</b>				\$25,918.73		\$ 4,022,766	\$ 3,862,017			\$ 236,951	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 4,022,766	\$ 3,862,017			\$ 236,951	15							

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>84,000</b>		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.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(84,000)</b>		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>168,000</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>413</b>		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>84,413</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>N/A</u>			8
	2006	<u>N/A</u>			9
	2007	<u>N/A</u>			10
	2008	<u>N/A</u>			11
	2009	<u>N/A</u>			12
<b>This facility was purchased from an unrelated entity in January 2008. A tax exemption has been denied, but no tax bill yet received.</b>					
<b>Amount accrued is an estimate if the tax exemption is not obtained, based on similar property tax bill.</b>					
				<b>FOR BHF USE ONLY</b>	
	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 of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Freeport Rehab & Health COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0049155

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

**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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>89-18-13-34-477-001</u>	<u>No bill yet received. See note on</u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                                    </u>	<u>page 10.</u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>			\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Freeport Rehab & Health

# 0049155

Report Period Beginning:

04/01/2009 Ending:

03/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 51,800 B. General Construction Type: Exterior Brick & Block Frame \_\_\_\_\_ Number of Stories 2

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. 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: \_\_\_\_\_  
3. Current Period Amortization: N/A 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>5 acres</u>		<u>\$ 86,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 86,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	143	2008		\$ 3,159,500	\$ 126,380	25	\$ 126,380	\$	\$ 273,823	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Cable System	2008		2,500	500	5	500		917	9
10	Boiler	2008		24,973	1,249	20	1,249		1,665	10
11	Remodel Bathroom	2008		7,087	545	13	545		999	11
12	Parking lot - Blacktop	2008		172,000	8,600	20	8,600		18,633	12
13	Roof Top Heating and Air Unit	2009		5,436	362	10	362		362	13
14	Emergency Generator	2010		34,927	291	20	291		291	14
15	Water Heater	2010		3,480	58	10	58		58	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

\*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



**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$	\$		\$	\$	\$	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	TOTAL (lines 4 thru 69)	\$ 3,409,903	\$ 137,985		\$ 137,985	\$	\$ 296,748	70

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

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	\$ 660,266	\$ 128,342	\$ 128,342	\$	5-15 yrs	\$ 273,594	71
72	Current Year Purchases	40,717	2,122	2,122		10-12 yrs	2,122	72
73	Fully Depreciated Assets							73
74	Indirect Costs							74
75	TOTALS	\$ 700,983	\$ 130,464	\$ 130,464	\$		\$ 275,716	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	Patient Care	2005 Ford Ecoline	2008	\$ 27,000	\$ 6,750	\$ 6,750	\$	4 yrs	\$ 14,625	76
77										77
78										78
79										79
80	TOTALS			\$ 27,000	\$ 6,750	\$ 6,750	\$		\$ 14,625	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)	\$ 4,223,886	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 275,199	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,199	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 587,089	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	1994 Dodge Station Wagon - 2008	\$ 3,000	\$ 750	\$ 1,625	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,000	\$ 750	\$ 1,625	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	<b>TOTAL</b>				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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	<b>TOTAL</b>		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (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.

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

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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.

Facility Name & ID Number Freeport Rehab & Health# 0049155Report Period Beginning: 04/01/2009Ending: 03/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2010

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 20,781	\$	1
2	Cash-Patient Deposits	27,293		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>82,538</u> )	804,564		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,233		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Recbl</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 887,871	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	86,000		13
14	Buildings, at Historical Cost	3,159,500		14
15	Leasehold Improvements, at Historical Cost	250,403		15
16	Equipment, at Historical Cost	730,983		16
17	Accumulated Depreciation (book methods)	(588,714)		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): <u>Construction in process</u>	5,289		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,643,461	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,531,332	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 21,942	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,293		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	54,435		31
32	Accrued Real Estate Taxes(Sch.IX-B)	168,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision payable</u>	1,255,512		36
37	<u>Current Maturity of Mortgage Note</u>	81,521		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,608,703	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,780,496		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,780,496	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,389,199	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (857,867)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,531,332	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(405,395)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(405,395)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(452,472)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(452,472)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(857,867)</b>	<b>24</b> *

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

Facility Name & ID Number Freeport Rehab & Health# 0049155Report Period Beginning: 04/01/2009Ending: 03/31/2010

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,510,676	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,510,676	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,795	6
7	Oxygen	20,778	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 25,573	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	570	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,492	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,062	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	872	24
25	Interest and Other Investment Income***	5,021	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,893	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>		28
28a	<b>See Att Sch VII</b>	5,824	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,824	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,550,028	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	926,321	31
32	Health Care	2,258,415	32
33	General Administration	1,137,479	33
<b>B. Capital Expense</b>			
34	Ownership	601,992	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	78,293	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,002,500	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(452,472)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (452,472)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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



Facility Name & ID Number **Freeport Rehab & Health**

# **0049155**

Report Period Beginning:

**04/01/2009**

Ending:

**03/31/2010**

**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	1,767	1,901	\$ 54,830	\$ 28.84	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	9,394	10,101	215,445	21.33	3
4	Licensed Practical Nurses	19,770	21,258	401,770	18.90	4
5	CNAs & Orderlies	66,629	71,645	729,342	10.18	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	6,528	7,020	80,936	11.53	10
11	Social Service Workers	1,685	1,812	27,178	15.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,991	23,647	237,886	10.06	15
16	Dishwashers					16
17	Maintenance Workers	3,713	3,997	59,088	14.78	17
18	Housekeepers	10,623	11,423	96,180	8.42	18
19	Laundry	4,792	5,153	44,111	8.56	19
20	Administrator	1,934	2,080	51,018	24.53	20
21	Assistant Administrator	1,465	1,575	21,890	13.90	21
22	Other Administrative			0		22
23	Office Manager					23
24	Clerical	4,906	5,275	72,168	13.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,965	2,113	22,506	10.65	31
32	Other Health Care(specify)	1,928	2,074	43,960	21.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,090	171,074	\$ 2,158,308 *	\$ 12.62	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	\$ 8,216	1-3	35
36	Medical Director	***	13,081	9-3	36
37	Medical Records Consultant	***	2,182	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,837	10-3	39
40	Physical Therapy Consultant	***	139,701	10a-3	40
41	Occupational Therapy Consultant	***	135,676	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	40,503	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 341,196		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Patricia Boomgarden	Administrator	None	\$ 16,222	Workers' Compensation Insurance	\$ 138,011	IDPH License Fee	\$	
Erica Sprenger	Administrator	None	34,796	Unemployment Compensation Insurance	47,694	Advertising: Employee Recruitment	5,066	
Amber Rucker	Asst. Admin	None	21,890	FICA Taxes	162,903	Health Care Worker Background Check (Indicate # of checks performed <u>25</u> )	250	
				Employee Health Insurance	57,296	Patient Background Checks	0	
				Employee Meals		Advertising - Promo & Yellow pages	20,468	
				Illinois Municipal Retirement Fund (IMRF)* 401(k)	5,569	Subscriptions	735	
				Other Employee Benefits	1,722	IHCA Dues	5,549	
						Other Licenses and Fees	1,344	
						Indirect Costs - See Att Sch III	54	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,908			Less: Public Relations Expense	( )	
						Non-allowable advertising	(20,468)	
						Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 413,195	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,998	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)	0
							Seminar Expense	480
							Less: non-allowable out-of-state travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Entertainment Expense	( )
				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 480
C. Professional Services								
Vendor/Payee	Type		Amount					
RFMS, Inc.	Administrative Services		\$ 171,600					
LTC Support Services, LLC	Support Services		150,000					
McGladrey & Pullen, LLP	Accounting Services		17,691					
RSM McGladrey	Tax Services		680					
My Innerview	Management Services		431					
Davis & Campbell L.L.C.	Legal Services		9					
Crain, Miller, & Wernsman, Ltd.	Legal Services		10,906					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 351,317					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Freeport Rehab & Health# 0049155Report Period Beginning: 04/01/2009Ending: 03/31/2010**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? Yes  
If YES, give association name and amount. See Page 21 Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 11 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,333 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 78,293  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,492
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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? 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? Yes  
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.