FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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:

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 01/01/2012 to 12/31/2012 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: 01/01/2012 Ending: 12/31/2012

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	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	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			1,545	1,545	8
9	SNF/PED					9
10	ICF	16,301	16,936		33,237	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,301	16,936	1,545	34,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.54%

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 1,545

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	166,085	8,326	9,101	183,512		183,512		183,512			1
2	Food Purchase		156,755		156,755	2,204	158,959	(754)	158,205			2
3	Housekeeping	115,432	12,986		128,418		128,418		128,418			3
4	Laundry	60,217	7,803		68,020		68,020		68,020			4
5	Heat and Other Utilities			99,666	99,666		99,666		99,666			5
6	Maintenance	46,996	16,067	41,706	104,769		104,769		104,769			6
7	Other (specify):*											7
8	TOTAL General Services	388,730	201,937	150,473	741,140	2,204	743,344	(754)	742,590			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,436,178	37,363	258,864	1,732,405	(2,204)	1,730,201		1,730,201			10
10a	Therapy			4,896	4,896		4,896		4,896			10a
11	Activities	44,440	4,020	1,588	50,048		50,048		50,048			11
12	Social Services	35,398		1,588	36,986		36,986		36,986			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,516,016	41,383	271,736	1,829,135	(2,204)	1,826,931		1,826,931			16
	C. General Administration											
17	Administrative	70,964		10,500	81,464		81,464		81,464			17
18	Directors Fees			4,300	4,300		4,300		4,300			18
19	Professional Services			161,873	161,873		161,873		161,873			19
20	Dues, Fees, Subscriptions & Promotions			16,937	16,937		16,937	(7,062)	9,875			20
21	Clerical & General Office Expenses	58,410	14,028	18,314	90,752		90,752	(11,105)	79,647			21
22	Employee Benefits & Payroll Taxes			281,587	281,587		281,587		281,587			22
23	Inservice Training & Education			50	50		50		50			23
24	Travel and Seminar			5,000	5,000		5,000		5,000			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			73,092	73,092		73,092		73,092			26
27	Other (specify):*											27
28	TOTAL General Administration	129,374	14,028	571,653	715,055		715,055	(18,167)	696,888			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,034,120	257,348	993,862	3,285,330		3,285,330	(18,921)	3,266,409			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 & ID Number FREEBURG CARE CENTER #0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			43,327	43,327		43,327	25,143	68,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,365	10,365		10,365	(9,425)	940			32
33	Real Estate Taxes			43,195	43,195		43,195		43,195			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			240,887	240,887		240,887	(128,282)	112,605			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,521	157,351	222,872		222,872		222,872			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			262,191	262,191		262,191		262,191			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		65,521	419,542	485,063		485,063		485,063			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,034,120	322,869	1,654,291	4,011,280		4,011,280	(147,203)	3,864,077			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 Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,569	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(754)	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	(10,855)	21		18
19	Entertainment				19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,012)	20		28
29	Other-Attach Schedule	(9,475)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,777)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(125,426)	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (125,426)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (147,203)		37

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

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

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

FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	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	(9,425)	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**	(9,475)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(754)	0	0	0	0	0	0	0	0	0	0	(754)	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**	(754)	0	0	0	0	0	0	0	0	0	0	(754)	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	(7,062)	0	0	0	0	0	0	0	0	0	0	(7,062)	20
21	Clerical & General Office Expenses	(11,105)	0	0	0	0	0	0	0	0	0	0	(11,105)	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**	(18,167)	0	0	0	0	0	0	0	0	0	0	(18,167)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,921)	0	0	0	0	0	0	0	0	0	0	(18,921)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	6,569	18,574	0	0	0	0	0	0	0	0	0	25,143	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,425)	0	0	0	0	0	0	0	0	0	0	(9,425)	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	(2,856)	(125,426)	0	0	0	0	0	0	0	0	0	(128,282)	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)	(21,777)	(125,426)	0	0	0	0	0	0	0	0	0	(147,203)	45

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NANCY L. LEONARD	3.45			ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
CHARLES W. BORRENPOHL	3.45			LAND TRUST		RENTAL
LAVONNE KAISER	3.45					
AMY MENGES	3.45					
KATHY L. LICKENBROCK	3.45					
DALE J. LICKENBROCK	3.45					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	VERLAN HEBERER	6.9						2
3	FRANK X. HEILIGENSTEIN	3.44						3
4	BARBARA HOLLAND	6.9						4
5	ALICE LANGSTRAAT	6.9						5
6	HERSCHEL PARRISH JR.	13.78						6
7	LARRY RHUTASEL, TRUSTEE	3.45						7
8	MARJORIE RHUTASEL, TRUSTEE	3.45						8
9	JOHN C. SCHAUFLER	20.7						9
10	CAROLYN STUMPF	6.9						10
11	DALE TOWERS DECLARATION OF	6.9						11
12	TRUST							12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LARRY RHUTASEL	CONSULTANT	ADM. CONS	3.45	NONE	2	5.00	ADM CONS	$ 6,600	17/3	1
2	JOHN SCHAUFLER	CONSULTANT	ADM. CONS	20.70	NONE	2	5.00	ADM CONS	3,900	17/3	2
3	DALE TOWERS	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	900	18/3	3
4	JOHN SCHAUFLER	DIRECTOR	board member	20.70	NONE	N/A	N/A	director fees	900	18/3	4
5	LARRY RHUTASEL	DIRECTOR	board member	3.45	NONE	N/A	N/A	director fees	900	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	board member	3.44	NONE	N/A	N/A	director fees	900	18/3	6
7	CAROLYN STUMPF	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fees	700	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,800		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: 01/01/2012 Ending: 2/31/2012

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: 01/01/2012 Ending: 12/31/2012

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CITIZENS COMMUNITY		X	LINE OF CREDIT	INT ONLY		200,000	25,000			940	6
7	BANK			OPERATING								7
8												8
9	TOTAL Facility Related						$ 200,000	$ 25,000			$ 940	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 200,000	$ 25,000			$ 940	15

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

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

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 43,195	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,695	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 43,195	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	36,880	8
	2008	39,420	9
	2009	40,831	10
	2010	41,944	11
	2011	43,195	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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-SUBT/TWP-IS-BLK	$ 43,150.00	$ 43,150.00
2.	14-29.0-400-038	LOT/SEC-29-SUBT/TWP-IS-BLK	$ 45.18	$ 45.18
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,195.18	$ 43,195.18

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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).

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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	208,917	5
6			1985	1986	3,116		30	104	104	2,756	6
7			1989	1989	2,110		27	78	78	1,872	7
8	10		1998	1997	411,348		39.5	10,415	10,415	161,381	8
	Improvement Type**										
9	PARKING LOT / TITLE INSURANCE			1981	7,109		30			7,109	9
10	SIDEWALK			1983	908		20			908	10
11	LAUNDRY RENOVATION			1983	3,303		25			3,303	11
12	STORAGE BUILDING			1983	6,690		20			6,690	12
13	WINDOW REPLACEMENT			1983	967		30	32	32	944	13
14	KITCHEN RENOVATIONS			1983	734		25			734	14
15	VENTILATION SYSTEM / INSULATION			1984	1,132		10			1,132	15
16	CONCRETE PAVING			1985	4,124		20			4,124	16
17	PARKING LOT			1986	2,518		10			2,518	17
18	STORAGE SHED			1987	10,213		15			10,213	18
19	DRIVEWAY			1988	3,990		15			3,990	19
20	DRIVEWAY			1989	1,465		15			1,465	20
21	ENTRY SIGN			1990	2,890		15			2,890	21
22	PARKING LOT			1990	11,951		20			11,951	22
23	SEWER			1990	17,548		25	702	702	15,795	23
24	LIGHTS			1990	1,140		10			1,140	24
25	HEAT PUMPS / COMPRESSOR			1990	2,527		8			2,527	25
26	SEWER REPAIRS/ DRIVEWAY REPAIRS / PLUMBING			1991	4,471		15			4,471	26
27	ROOFTOP AIR CONDITIONER			1991	4,600		8			4,600	27
28	FRONT OFFICE REMODELING / DRIVEWAY REPAIRS			1992	10,838		15			10,838	28
29	CARPET			1992	14,036		5			14,036	29
30	PARKING LOT AND DRIVEWAY			1993	14,900		15			14,900	30
31	FENCE / PARKING LOT & DRIVEWAY			1994	6,672		15			6,672	31
32	CEILING TILE			1994	1,310		5			1,310	32
33	LANDSCAPING			1996	1,499		10			1,499	33
34	WATER HEATER			1996	3,426		15			3,426	34
35	5 TON CONDENSING UNIT			1996	1,195		10			1,195	35
36	WATER LINE & GAS LINE FOR ADDITION			1997	633		10			633	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR COMRESSOR FOR FIRE SYSTEM	1997	$ 1,244	$ 41	10	$	$ (41)	$ 1,244	37
38	CERAMIC TILE & LABOR FOR SHOWERS	1997	5,795	198	10	198		5,795	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	142	5	142		4,274	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		5,872	44
45	gutting old								45
46	expanded care plan office adding countertop & windows	1998	6,952	463	15	463		6,714	46
47	FIRE ALARM	1998	4,431	295	15	295		4,278	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		2,827	48
49	PHONE JACKS INTALLED	1998	777	52	15	52		754	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10			3,884	50
51	replaced ceiling tile & construced new storage cabinets in	1999	4,951		10			4,951	51
52	activity room								52
53	ROOF TOP FAN	1999	866	58	15	58		783	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		3,051	54
55	NEW ROOF ON WINGS A, B, & C	1999	16,397		10			16,397	55
56	WALLPAPAER IN DINING ROOM	2000	1,255		5			1,255	56
57	gutted bathroom installed window & worktop to convert to	2000	2,374		10			2,374	57
58	DON office								58
59	finish DON office - mudd, sand, and paint room, set cabinets	2001	2,194		10			2,194	59
60	& build shelves. Put carpet & cove base down & handrail up								60
61	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		1,345	61
62	remove old shower on d-hall and put in new shower walls	2001	2,097		10			2,097	62
63	and mudd, sand, and paint to seal plaster around shower								63
64	tear out wall between secretary and bookkeeper office	2003	6,638	664	10	664		6,308	64
65	and build countertops and workspace, new carpet, paint, etc								65
66	BUILD UP ROOF SECTION	2004	8,072	807	10	807		6,860	66
67	NEW ROOF ON FLAT PART OF BUILDING	2005	66,376		10	6,638	6,638	49,785	67
68	firewall laundry room, fire ducts & ceiling tiles in oxygen room	2005	7,588	759	10	759		5,692	68
69	replace smoke detectors	2005	4,457	446	10	446		3,345	69
70	TOTAL (lines 4 thru 69)		$ 2,139,270	$ 4,868		$ 30,393	$ 25,525	$ 1,845,493	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,139,270	$ 4,868		$ 30,393	$ 25,525	$ 1,845,493	1
2	5 TON AIR CONDITIONER	2006	4,621	462	10	462		3,003	2
3	SIDEWALKS, LIGHTING, & LANDSCAPING	2006	16,064		15	1,071	1,071	6,961	3
4	PARKING LOT	2006	6,748		15	450	450	2,925	4
5	REPLACE PARTS OF BACKFLOW PREVENTOR	2007	5,801	580	10	580		3,190	5
6	LANDSCAPE FRONT OF BUILDING	2007	10,345	1,035	10	1,035		5,692	6
7	REMOVE & REPLACE OLD SIDEWALKS & PARKING LOT	2007	29,079	1,939	15	1,939		10,664	7
8	CANOPY ADDITION	2008	15,191	1,013	15	1,013		4,558	8
9	DAWN TO DUSK LIGHTING	2008	1,543	154	10	154		693	9
10	D2 DOORS REPLACED	2009	3,321	221	15	221		774	10
11	5 TON ROOFTOP UNIT	2009	7,217	722	10	722		2,527	11
12	ROOFTOP REPAIR WEST WING	2009	7,375	1,054	7	1,054		3,689	12
13	remove and redesign nurses station, new cabinets, floor	2010	17,500	1,750	10	1,750		4,375	13
14	and countertops								14
15	repair kitchen wall for damage from leaking, new FRP	2010	3,000	600	5	600		1,500	15
16	covering and covebase, one structurally fixed								16
17	2 EXIT DOORS AND HARDWARE	2010	2,408	161	15	161		402	17
18	repair to sprinkler system due to leaking and rusting	2010	3,983	398	10	398		995	18
19	replaced piping and got system operational								19
20	52 DOORS AND HINGES	2010	23,732	1,582	15	1,582		3,955	20
21	ALL OTHER DOORS AND HINGES	2011	37,880	2,525	15	2,525		3,788	21
22	FLOORING VCT TILE HALLS A,B, & C	2011	14,004	1,400	10	1,400		2,100	22
23	2 COUNTERTOPS IN KITCHEN	2011	2,807	281	10	281		421	23
24	NEW PART OF PARKING LOT	2011	12,000	800	15	800		1,200	24
25	NEW D HALL ROOF	2011	6,995	700	10	700		1,050	25
26	laundry combustion air and ceiling drywall	2012	13,234	662	10	662		662	26
27	C-HALL ROOF REPLACED	2012	13,000	650	10	650		650	27
28	A-HALL ROOF REPLACED	2012	13,225	661	10	661		661	28
29	REPLACED FRONT ENTRY GLASS	2012	2,055	69	15	69		69	29
30	TEST ON 9 SPRINKLER HEADS & REPLACED	2012	4,360	145	15	145		145	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,416,758	$ 24,432		$ 51,478	$ 27,046	$ 1,912,142	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 166,234	$	$ 15,717	$ 15,717	various	$ 68,521	71
72	Current Year Purchases	18,895	18,895	1,275	(17,620)	various	1,275	72
73	Fully Depreciated Assets	496,451				various	496,451	73
74								74
75	TOTALS	$ 681,580	$ 18,895	$ 16,992	$ (1,903)		$ 566,247	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,120,818	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,327	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,470	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,143	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,478,389	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: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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	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: 01/01/2012 Ending: 12/31/2012

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: 01/01/2012 Ending: 12/31/2012

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	hrs	$	923	$ 64,274	$	923	$ 64,274	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		149	12,201		149	12,201	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3:39/2	hrs		1,131	77,727	88	1,131	77,815	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				44,091		44,091	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				3,149	21,342		24,491	13
14	TOTAL			$	2,203	$ 157,351	$ 65,521	2,203	$ 222,872	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.

STATE OF ILLINOIS

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 140,006	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,621,221		3
4	Supply Inventory (priced at)	3,055		4
5	Short-Term Investments	24,608		5
6	Prepaid Insurance	16,330		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)**	$ 1,805,220	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	446,930		15
16	Equipment, at Historical Cost	514,136		16
17	Accumulated Depreciation (book methods)	(757,298)		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)**	$ 203,768	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,008,988	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 142,463	$	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	77,123		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,466		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	10,287		36
37	ACCR OCCUPIED BED TAX	101,896		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 692,735	$	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	LINE OF CREDIT CITIZENS	25,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 25,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 717,735	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,291,253	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,008,988	$	48

*(See instructions.)

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 809,781	1
2	Restatements (describe):		2
3	**adjust 2011 for dpa rate increase 5/11**	76,194	3
4	**adjust 2011 for new occupied bed tax 7/11**	(96,294)	4
5	**2011 Illinois taxes paid**	(5,634)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 784,047	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	507,206	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 507,206	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,291,253	24 *

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,157,781	1
2	Discounts and Allowances for all Levels	93,357	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,251,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,360	6
7	Oxygen	10,442	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,802	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	710	19
20	Radiology and X-Ray	2,089	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,799	23
	D. Non-Operating Revenue		
24	Contributions	325	24
25	Interest and Other Investment Income***	1,422	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,747	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)**	$ 4,518,486	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	741,140	31
32	Health Care	1,829,135	32
33	General Administration	715,055	33
	B. Capital Expense		
34	Ownership	240,887	34
	C. Ancillary Expense		
35	Special Cost Centers	222,872	35
36	Provider Participation Fee	262,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,011,280	40
41	**Income before Income Taxes (line 30 minus line 40)****	507,206	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 507,206	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,697,164	44
45	Private Pay - Net Inpatient Revenue	2,207,776	45
46	Medicare - Net Inpatient Revenue	344,895	46
47	Other-(specify) vending income & prior yr adj	105	47
48	Other-(specify) oximeter income	1,198	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,251,138	49

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

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

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

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

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	3,979	4,411	$ 105,060	$ 23.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,504	2,613	66,571	25.48	3
4	Licensed Practical Nurses	22,859	25,065	475,660	18.98	4
5	CNAs & Orderlies	57,275	60,466	755,502	12.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,393	3,687	44,440	12.05	9
10	Activity Assistants					10
11	Social Service Workers	1,912	2,064	35,398	17.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,881	2,085	27,871	13.37	14
15	Cook Helpers/Assistants	13,533	14,354	138,214	9.63	15
16	Dishwashers					16
17	Maintenance Workers	3,184	3,450	46,996	13.62	17
18	Housekeepers	10,772	11,282	115,432	10.23	18
19	Laundry	5,922	6,362	60,217	9.47	19
20	Administrator	1,832	2,064	70,964	34.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,706	4,115	58,410	14.19	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	1,992	2,192	33,385	15.23	33
34	TOTAL (lines 1 - 33)	134,744	144,210	$ 2,034,120 *	$ 14.11	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	181	$ 9,101	1/3	35
36	Medical Director		4,800	9/3	36
37	Medical Records Consultant	16	800	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,450	10/3	39
40	Physical Therapy Consultant	71	4,388	10A/3	40
41	Occupational Therapy Consultant	7	497	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	11	10A/3	43
44	Activity Consultant	24	1,588	11/3	44
45	Social Service Consultant	25	1,588	12/3	45
46	Other(specify)				46
47	ADMINISTRATIVE		10,500	17/3	47
48	BILLING CONSULTANT		300	19/3	48
49	TOTAL (lines 35 - 48)	325	$ 37,023		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	1,915	63,914	10/3	51
52	Certified Nurse Assistants/Aides	9,426	190,700	10/3	52
53	TOTAL (lines 50 - 52)	11,341	$ 254,614		53

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN HUELSKAMP	ADMINISTRATOR	0	$ 13,794
LAURA NORTHWAY	ADMINISTRATOR	0	57,170
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,964

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANTS	$ 10,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MANAGEMENT	MANAGEMENT	$ 160,608
RICHARD BRESLIN	TAX RETURN PREP	915
INNOVATIVE SOLUTIONS	BILLING CONSULTANT	300
THOMAS LECHIEN	LAWYER	50
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 161,873

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,538
Unemployment Compensation Insurance	40,933
FICA Taxes	155,610
Employee Health Insurance	6,560
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSES	12,708
VACCINES	1,043
EMPLOYEE PARTIES, AWARDS, GIFTS, ETC	6,195
TOTAL (agree to Schedule V, line 22, col.8)	$ 281,587

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	$ 1,494
Advertising: Employee Recruitment	2,495
Health Care Worker Background Check	1,064
(Indicate # of checks performed 38)	
Patient Background Checks 86	1,280
other adv (7012) chamber of comm (50)	7,062
subs(572)corp fee (100) bus lic(10)	682
allsc(1767)iapa(35)san lic(35)	1,837
health ins(350) mc reenroll(523) clia(150)	1,023
elim chamber of comm	(50)
Less: Public Relations Expense	( )
Non-allowable advertising	(7,012)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,875

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,847
Seminar Expense	3,153
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,000

**See instructions.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$	$	$	$	$	$	$

Facility Name & ID Number FREEBURG CARE CENTER **#** 0025098 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8 YRS**

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

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **262,191**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

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

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

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

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

FREEBURG CARE CENTER
SCHEDULE OF RECLASSIFICATIONS FOR PGS 3&4 COL 5
12/31/2012
ID#0025098

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	2204	
10	MEDICAL SUPPLIES		2204
	RECL FOOD SUPPLEMENTS		