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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 3/14/79

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: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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: 1/1/2014 Ending: 12/31/2014

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,095	16,634	2,463	23,192	8
9	SNF/PED					9
10	ICF	10,302	1,763		12,065	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,397	18,397	2,463	35,257	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.86%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,463

Medicare Intermediary Cigna Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Freeburg Care Center # 0025098 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,601	9,353	11,802	191,756		191,756		191,756			1
2	Food Purchase		167,716		167,716		167,716	(7,272)	160,444			2
3	Housekeeping	128,466	13,635		142,101		142,101		142,101			3
4	Laundry	61,129	14,091		75,220		75,220		75,220			4
5	Heat and Other Utilities			115,927	115,927		115,927		115,927			5
6	Maintenance	49,562	27,880	45,606	123,048		123,048		123,048			6
7	Other (specify):*											7
8	**TOTAL General Services**	409,758	232,675	173,335	815,768		815,768	(7,272)	808,496			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,735,659	59,922	147,606	1,943,187		1,943,187		1,943,187			10
10a	Therapy											10a
11	Activities	40,396	10,530	1,674	52,600		52,600		52,600			11
12	Social Services	38,017		1,674	39,691		39,691		39,691			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,814,072	70,452	155,754	2,040,278		2,040,278		2,040,278			16
	C. General Administration											
17	Administrative	77,229	16,251	178,461	271,941		271,941		271,941			17
18	Directors Fees			8,000	8,000		8,000		8,000			18
19	Professional Services			15,096	15,096		15,096	(689)	14,407			19
20	Dues, Fees, Subscriptions & Promotions			34,262	34,262		34,262	(12,383)	21,879			20
21	Clerical & General Office Expenses	53,852		7,342	61,194		61,194	(1,793)	59,401			21
22	Employee Benefits & Payroll Taxes			296,739	296,739		296,739	7,272	304,011			22
23	Inservice Training & Education			406	406		406		406			23
24	Travel and Seminar			2,890	2,890		2,890		2,890			24
25	Other Admin. Staff Transportation		1,999		1,999		1,999		1,999			25
26	Insurance-Prop.Liab.Malpractice			81,586	81,586		81,586		81,586			26
27	Other (specify):*											27
28	**TOTAL General Administration**	131,081	18,250	624,782	774,113		774,113	(7,593)	766,520			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,354,911	321,377	953,871	3,630,159		3,630,159	(14,865)	3,615,294			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:** 1/1/2014 **Ending:** 12/31/2014

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			53,981	53,981		53,981	20,438	74,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,425	9,425		9,425	(9,425)				32
33	Real Estate Taxes			44,502	44,502		44,502		44,502			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			1,460	1,460		1,460		1,460			35
36	Other (specify):*											36
37	**TOTAL Ownership**			253,368	253,368		253,368	(132,987)	120,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,230	158,877	238,107		238,107		238,107			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,583	258,583		258,583		258,583			42
43	Other (specify):* Non-Allowable Cos			16,026	16,026		16,026	(16,026)				43
44	**TOTAL Special Cost Centers**		79,230	433,486	512,716		512,716	(16,026)	496,690			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,354,911	400,607	1,640,725	4,396,243		4,396,243	(163,878)	4,232,365			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: 1/1/2014 Ending: 12/31/2014

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	1,864	30		9
10	Interest and Other Investment Income	(9,425)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(886)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(713)	43		18
19	Entertainment				19
20	Contributions	(847)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(689)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,936)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(25,820)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,452)		$	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)		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))**	$ (163,878)		37

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

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

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

Freeburg Care Center

ID# 0025098

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (8,458)	43	1
2	X-Rays	(3,186)	43	2
3	Miscellaneous Income	(1,793)	21	3
4	Public Relations	(12,333)	20	4
5	Chamber of Commerce	(50)	20	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**	(25,820)		49

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG 6-Supp		See PG 6-Supp		See PG 6-Supp		

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	30	Depreciation	$	St. Clair Estates	100.00%	$ 18,574	$ 18,574	1
2	V	34	Rent	144,000	St. Clair Estates	100.00%		(144,000)	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: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	John C. Schaufler	20.7			St. Clair Estate	Freeburg	Real Estate	1
2	Herschel Parrish Jr.	13.75			Land Trust			2
3	Verlan Heberer	6.9						3
4	Barbara Holland	6.9						4
5	Alice Langstraat	6.9						5
6	Carolyn Stumpf	6.9						6
7	Dale Towers Declaration of Trust	6.9						7
8	Nancy L. Leonard	3.45						8
9	Charles W. Borrenpohl	3.45						9
10	Lavonne Kaiser	3.45						10
11	Amy Menges	3.45						11
12	Kathy L. Lickenbrock	3.45						12
13	Dale J. Lickenbrock	3.45						13
14	Larry Rhutasel,Trustee	3.45						14
15	Marjorie Rhutasel, Trustee	3.45						15
16	Frank X. Heiligenstein	3.44						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Rhutasel	Consultant	Admin Consultant	3.45	None	2	5.00	Admin Cons.	$ 8,250	19(3)	1
2	John Schaufler	Consultant	Admin Consultant	20.70	None	2	5.00	Admin Cons.	5,100	19(3)	2
3	Dale Towers	Director	Board Member	6.90	None	N/A	N/A	Director Fees	1,600	18(3)	3
4	John Schaufler	Director	Board Member	20.70	None	N/A	N/A	Director Fees	1,600	18(3)	4
5	Larry Rhutasel	Director	Board Member	3.45	None	N/A	N/A	Director Fees	1,600	18(3)	5
6	Frank Heiligenstein	Director	Board Member	3.44	None	N/A	N/A	Director Fees	1,600	18(3)	6
7	Carolyn Stumpf	Director	Board Member	6.90	None	N/A	N/A	Director Fees	1,600	18(3)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,350		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: 1/1/2014 Ending: 2/31/2014

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 N/A
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: 1/1/2014 Ending: 12/31/2014

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	Shareholder Loan	X		Working Capital	Demand	1/1/94	290,000	290,000	1/1/15	0.0325	9,425	6
7												7
8												8
9	TOTAL Facility Related						$ 290,000	$ 290,000			$ 9,425	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(9,425)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,425)	14
15	TOTALS (line 9+line14)						$ 290,000	$ 290,000			$	15

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

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

**** 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: 1/1/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)	2013	$ 44,502	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,002	3
4. Real Estate Tax accrual used for 2014 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.		$ 44,502	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	40,831	8
	2010	41,944	9
	2011	43,195	10
	2012	41,870	11
	2013	44,502	12

This entity accrues the same real estate taxes each year.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 Brenda Cullum

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-29.0-400-040	Long Term Care Property	$ 44,468.60	$ 44,468.60
2.	14-29.0-400-038	Long Term Care Property	$ 33.66	$ 33.66
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,502.26	$ 44,502.26

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 1/1/2014 Ending: 12/31/2014

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. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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: 1/1/2014 Ending: 12/31/2014

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	$ 1,174,206	$	30	$	$	$ 1,174,206	4
5	10			1985	227,899		30	7,597	7,597	224,111	5
6				1985	3,116		30	104	104	2,964	6
7				1989	2,110		27	78	78	2,028	7
8	10			1997	411,348		39.5	10,415	10,415	182,211	8
	Improvement Type**										
9	Parking Lot/title Insurance			1981	7,109		30			7,109	9
10	Sidewalk			1983	908		20			908	10
11	Laundry Renovation			1983	3,303		25			3,303	11
12	Storage Building			1983	6,690		20			6,690	12
13	Window Replacement			1983	967		30			967	13
14	Kitchen Renovations			1983	734		25			734	14
15	Ventilation System/ Insulation			1984	1,132		10			1,132	15
16	Concrete Paving			1985	4,124		20			4,124	16
17	Parking Lot			1986	2,518		10			2,518	17
18	Driveway			1987	3,990		15			3,990	18
19	Driveway			1988	1,465		15			1,465	19
20	Entry Sign			1989	2,890		15			2,890	20
21	Parking Lot			1990	11,951		20			11,951	21
22	Sewer			1990	17,548		25	702	702	17,199	22
23	Lights			1990	1,140		10			1,140	23
24	Heat Pumps/compressor			1990	2,527		8			2,527	24
25	Sewer Repairs/driveway Repairs/plumbing			1991	4,471		15			4,471	25
26	Rooftop Air Conditioner			1991	4,600		8			4,600	26
27	Front Office Remodeling/ Driveway Repairs			1992	10,838		15			10,838	27
28	Carpet			1992	14,036		5			14,036	28
29	Parking Lot And Driveway			1993	14,900		15			14,900	29
30	Fence/parking Lot & Driveway			1994	6,672		15			6,672	30
31	Ceiling Tile			1994	1,310		5			1,310	31
32	Landscaping			1996	1,499		10			1,499	32
33	Water Heater			1996	3,426		15			3,426	33
34	5 Ton Condensing Unit			1996	1,195		10			1,195	34
35	Water Line & Gas Line For Addition			1997	633		10			633	35
36	Air Compressor For Fire System			1997	1,244		10			1,244	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	Ceramic Tile & Labor For Showers	1997	5,795		10		$	$ 5,795	37
38	Rock & Road Grading	1997	502		15			502	38
39	Remove Driveway & Reconcrete	1997	4,274		5			4,274	39
40	Labor & Material To Build Wall In Laundry Room	1997	503		15			503	40
41	Telephone System	1997	4,640		10			4,640	41
42	8 Ge Heat/cool Units	1997	7,624		10			7,624	42
43	Cabinets, Countertops & Labor For New Nurses Station And	1998	6,073		15			6,073	43
44	Gutting Old								44
45	Expanded Care Plan Office Adding Countertop & Windows	1998	6,952		15			6,952	45
46	Fire Alarm	1998	4,431		15			4,431	46
47	5 Ton Heating A/c Unit Roof Top	1998	2,918		15			2,918	47
48	Phone Jacks Installed	1998	777		15			777	48
49	4 Ge Heat/coot Units	1998	3,884		10			3,884	49
50	Replaced Ceiling Tile&Constructed New Storage Cabinets In	1999	4,951		10			4,951	50
51	Activity Room								51
52	Roof Top Fan	1999	866	25	15	25		866	52
53	Work On Rooftop A/c Unit	1999	3,170		14			3,170	53
54	New Roof On Wings A, B & C	1999	16,397		10			16,397	54
55	Wallpaper In Dining Room	2000	1,255		5			1,255	55
56	Gutted Bathroom, Installed Window & Worktop To Convert	2000	2,374		10			2,374	56
57	to DON Office								57
58	Finish Don Office-Mudd, Sand, And Paint Room, set cabinets	2001	2,194		10			2,194	58
59	&Build Shelves. Put Carpet &Cove Base Down& Handrail Up								59
60	Remove & Repair Concrete Entrance Sidewalk	2001	1,750	117	15	117		1,579	60
61	Remove Old Shower On D-hall & Put In New Shower Walls	2001	2,097		10			2,097	61
62	And Mudd, Sand, And Paint To Seal Plaster Around Shower								62
63	Tear Out Wall Between Secretary And Bookkeeper Office	2003	6,638		10			6,638	63
64	Build Countertops And Workspace, New Carpet, Paint, Etc								64
65	Build Up Roof Section	2004	8,072	405	10	405		8,072	65
66	New Roof On Flat Part Of Building	2005	66,376		10	6,638	6,638	63,061	66
67	firewall laundry room, fire ducts & ceiling tiles-oxygen room	2005	7,588	759	10	759		7,210	67
68	Replace Smoke Detectors	2005	4,457	446	10	446		4,237	68
69	5 Ton Air Conditioner	2006	4,621	462	10	462		3,927	69
70	TOTAL (lines 4 thru 69)		$ 2,133,678	$ 2,214		$ 27,748	$ 25,534	$ 1,895,392	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: 1/1/2014 Ending: 12/31/2014

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		$ 2,133,678	$ 2,214		$ 27,748	$ 25,534	$ 1,895,392	1
2	Sidewalks, Lighting, & Landscaping	2006	16,064		15	1,071	1,071	9,103	2
3	Parking Lot	2006	6,748		15	450	450	3,825	3
4	Replace Parts Of Backflow Preventor	2007	5,801	580	10	580		4,350	4
5	Landscape Front Of Building	2007	10,345	1,035	10	1,035		7,762	5
6	Remove & Replace Old Sidewalks & Parking Lot	2007	29,079	1,939	15	1,939		14,542	6
7	Canopy Addition	2008	15,191	1,013	15	1,013		6,584	7
8	Dawn To Dusk Lighting	2008	1,543	154	10	154		1,002	8
9	D2 Doors Replaced	2009	3,321	221	15	221		1,216	9
10	5 Ton Rooftop Unit	2009	7,217	722	10	722		3,971	10
11	Rooftop Repair West Wing	2009	7,375	1,054	7	1,054		5,797	11
12	Remove And Redesign Nurses Station, New Cabinets, Floor	2010	17,500	1,750	10	1,750		7,875	12
13	And Countertops								13
14	Repair Kitchen Wall For Damage From Leaking, New Frp	2010	3,000	600	5	600		2,700	14
15	Covering And Covebase And Structurally Fixed								15
16	2 Exit Doors And Hardware	2010	2,408	161	15	161		724	16
17	Repair To Sprinkler System Due To Leaking And Rusting	2010	3,983	398	10	398		1,791	17
18	Replaced Piping And Got System Operational								18
19	52 Doors And Hinges	2010	23,732	1,582	15	1,582		7,119	19
20	All Other Doors And Hinges	2011	37,880	2,525	15	2,525		8,838	20
21	Flooring Vct Tile Halls A,b,&c	2011	14,004	1,400	10	1,400		4,900	21
22	2 Countertops In Kitchen	2011	2,807	281	10	281		983	22
23	New Part Of Parking Lot	2011	12,000	800	15	800		2,800	23
24	New D Hall Roof	2011	6,995	700	10	700		2,450	24
25	Laundry Combustion Air And Ceiling Drywall	2012	13,234	1,323	10	1,323		3,308	25
26	C-hall Roof Replaced	2012	13,000	1,300	10	1,300		3,250	26
27	A-hall Roof Replaced	2012	13,225	1,323	10	1,323		3,307	27
28	Replaced Front Entry Glass	2012	2,055	137	15	137		343	28
29	Test On 9 Sprinkler Heads & Replaced	2012	4,360	291	15	291		727	29
30	Install Hot Water Heater	2013	8,866	887	10	887		1,330	30
31	Replace Dry Sprinkler Pendants	2013	11,500	1,150	10	1,150		1,725	31
32	Replace Windows In Rooms 1-7	2013	3,137	314	10	314		471	32
33	Install Air Handler In Janitors Closet	2013	4,540	227	20	227		341	33
34	TOTAL (lines 1 thru 33)		$ 2,434,588	$ 26,081		$ 53,136	$ 27,055	$ 2,008,526	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: 1/1/2014 Ending: 12/31/2014

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 12B, Carried Forward		$ 2,434,588	$ 26,081		$ 53,136	$ 27,055	$ 2,008,526	1
2									2
3	Storage Building	2014	2,540	127	20	64	(63)	64	3
4	Carpet in Admin Offices	2014	2,742	275	5	274	(1)	274	4
5	B Hall Room Replaced	2014	3,575	179	10	179		179	5
6	Replaced Ceiling Tile and Lights in Lobby Area	2014	5,562	348	8	348		348	6
7	Replaced Metal siding on shed	2014	8,850	443	10	443		443	7
8	Replaced Roof on Shed	2014	2,637	132	10	132		132	8
9	AC Condensing Unit on D Wing	2014	2,731	137	15	91	(46)	91	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,463,225	$ 27,722		$ 54,667	$ 26,945	$ 2,010,057	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: 1/1/2014 Ending: 12/31/2014

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	$ 174,223	$	$ 17,492	$ 17,492		$ 81,542	71
72	Current Year Purchases	26,259	26,259	2,260	(23,999)		2,260	72
73	Fully Depreciated Assets	519,859					519,859	73
74								74
75	TOTALS	$ 720,341	$ 26,259	$ 19,752	$ (6,507)		$ 603,661	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				$	$	$	$	5	$	76
77	N/A									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)	$ 3,206,046	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,981	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 74,419	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,438	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,613,717	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 [X] 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:				$ N/A			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. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 1,460 Description: See Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name: **Freeburg Care Center**
IDPH License ID Number: **0025098**
Fiscal Year End: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
BIPAP	313
Low Air Mat	525
Wound Vac	210
Rug Doc	52
Storage Building	360
Total - Line 16	**1,460**

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$	858	$ 57,954	$	858	$ 57,954	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		223	18,312		223	18,312	2
3	Licensed Recreational Therapist	39 (2), (3)	hrs		1,282	77,614	50	1,282	77,664	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	39(2)	# of prescrpts				67,175		67,175	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch 16A	39(2)					12,005		12,005	12
13	Other (specify):									13
14	TOTAL			$	2,363	$ 153,880	$ 79,230	2,363	$ 233,110	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: **Tabor Hills Health Care Facility, Inc.**
IDPH License ID Number: **0040543**
Fiscal Year End: **1/0/1900**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description		Supplies
Oxygen		11,191
IV Therapy		220
Cardiology		594
Total - Line 12	**-**	**12,005**

STATE OF ILLINOIS

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 586,929	$ 586,929	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (3,218))	1,345,673	1,345,673	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,109	10,109	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Capital	20,650	20,650	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,963,361	$ 1,963,361	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,046,294	22,480	13
14	Buildings, at Historical Cost		1,818,679	14
15	Leasehold Improvements, at Historical Cost		644,546	15
16	Equipment, at Historical Cost		720,341	16
17	Accumulated Depreciation (book methods)	(839,945)	(2,613,717)	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 (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 206,349	$ 592,329	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,169,710	$ 2,555,690	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,155	$ 79,155	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,525	108,525	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,460	36,460	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,500	41,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	59,277	59,277	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 324,917	$ 324,917	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	290,000	290,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 290,000	$ 290,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 614,917	$ 614,917	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,554,793	$ 1,940,773	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,169,710	$ 2,555,690	48

***(See instructions.)**

Facility Name: **Freeburg Care Center**
IDPH License ID Number: **0025098**
Fiscal Year End: **12/31/2014**

Schedule 17A

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

Description	Operating	After Consolidation
MANAGEMENT FEES PAY	14,562	14,562
INSURANCE	438	438
ACCRUED SALES TAX	296	296
401K LIABILITY	8,692	8,692
PRETAX INSURANCE	138	138
ACCR LIC BED TAX	35,151	35,151
Total - Line 36	**59,277**	**59,277**

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,359,887	1
2	Restatements (describe):		2
3	**2013 Illinois Taxes Paid**	(3,220)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,356,667	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	502,626	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	(304,500)	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)**	$ 198,126	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)**	$ 1,554,793	24 *

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

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 4,340,257	1
2	Discounts and Allowances for all Levels	165,073	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,505,330	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	281,245	6
7	Oxygen	2,696	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 283,941	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	69,499	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,768	19
20	Radiology and X-Ray	1,766	20
21	Other Medical Services	20,036	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 102,069	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,401	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,401	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	4,128	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,128	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,898,869	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	815,768	31
32	Health Care	2,040,278	32
33	General Administration	774,113	33
	B. Capital Expense		
34	Ownership	253,368	34
	C. Ancillary Expense		
35	Special Cost Centers	254,133	35
36	Provider Participation Fee	258,583	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,396,243	40
41	**Income before Income Taxes (line 30 minus line 40)****	502,626	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 502,626	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,708,550	44
45	Private Pay - Net Inpatient Revenue	2,562,960	45
46	Medicare - Net Inpatient Revenue	502,504	46
47	Other-(specify) Prior Year Adjustments	(268,684)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,505,330	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

^ - This entity is a cash basis taxpayer

Facility Name: **Freeburg Care Center**
IDPH License ID Number: **0025098**
Fiscal Year End: **12/31/2014**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
OTHER INCOME	2977
ACT & CONT INCOME	655
VENDING INCOME	496
Total - Line 28	**4,128**

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	3,923	4,155	$ 108,087	$ 26.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,596	7,905	201,420	25.48	3
4	Licensed Practical Nurses	20,099	21,764	439,347	20.19	4
5	CNAs & Orderlies	71,117	74,457	951,494	12.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,187	3,478	40,396	11.61	10
11	Social Service Workers	1,921	2,093	38,017	18.16	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,134	32,518	15.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,410	13,991	138,083	9.87	15
16	Dishwashers					16
17	Maintenance Workers	3,010	3,303	49,562	15.01	17
18	Housekeepers	10,349	11,333	128,466	11.34	18
19	Laundry	5,907	6,243	61,129	9.79	19
20	Administrator	1,800	2,032	77,229	38.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,731	4,059	53,852	13.27	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 C: Ward Clerk	1,964	2,180	35,311	16.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,976	159,127	$ 2,354,911 *	$ 14.80	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	264	$ 11,802	1(3)	35
36	Medical Director	Monthly	4,800	9(3)	36
37	Medical Records Consultant	16	800	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,519	10(3)	39
40	Physical Therapy Consultant	81	4,094	39(3)	40
41	Occupational Therapy Consultant	12	835	39(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	68	39(3)	43
44	Activity Consultant	30	1,674	11(3)	44
45	Social Service Consultant	30	1,674	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	435	$ 29,266		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	24	$ 1,006	10(3)	50
51	Licensed Practical Nurses	751	24,674	10(3)	51
52	Certified Nurse Assistants/Aides	5,615	117,607	10(3)	52
53	TOTAL (lines 50 - 52)	6,390	$ 143,287		53

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Northway	Administrator	0	$ 77,229
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,229

B. Administrative - Other

Description	Amount
Management Fees	$ 178,461
TOTAL (agree to Schedule V, line 17, col. 3)	$ 178,461
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Richard Breslin	Accounting	$ 970
Greensfelder, Hemker & Gale P.C.	Legal	689
Tom Lechien	Legal	88
John Schaulfer	Administrative Consultant	5,100
Larry Rhutasel	Administrative Consultant	8,250
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 15,096

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,133
Unemployment Compensation Insurance	39,269
FICA Taxes	180,150
Employee Health Insurance	
Employee Meals	7,272
Illinois Municipal Retirement Fund (IMRF)*	
Vaccines	1,928
Other Employee Benefits	13,392
401(k) Expense	7,867
TOTAL (agree to Schedule V, line 22, col.8)	$ 304,011

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	25,391
Health Care Worker Background Check	
(Indicate # of checks performed 24)	696
Patient Background Checks 102	1,530
Miscellaneous Licenses & Fees	400
Miscellaneous Dues & Subs	4,253
Less: Chamber of Commerce	(50)
Less: Public Relations Expense	(12,333)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,879

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,890
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,890

**See instructions.

Facility Name: **Freeburg Care Center**
IDPH License ID Number: **0025098**
Fiscal Year End: **12/31/2014**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Professional Fees from Schedule XIX Section C		15,096
Less: Non-Allowable Legal Fees		(689)
	Total (agree to Schedule V, line 19, column 8)	14,407

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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			$		$	$	$	$	$	$	$	$	$
2													
3												N/A	
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(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 **N/A**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **258,583**
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. $ **7,272** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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? **N/A**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees.