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: 0049155

Facility Name: Freeport Rehab & Health

Address: 900 S Kiwanis Dr (Number) Freeport (City) 61032 (Zip Code)

County: Stephenson

Telephone Number: (815) 235-6196 **Fax #** (815) 235-5365

HFS ID Number:

Date of Initial License for Current Owners: 02/01/08

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550
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 4/1/2013 to 3/31/2014 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) Darcee Fanning
(Title) Regional Director

Paid Preparer

(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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 _____

	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	143	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	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	12,729	3,641	3,849	20,219	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,729	3,641	3,849	20,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 38.74%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] 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 02/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 143 and days of care provided 2,940

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 3/31/2014 Fiscal Year: 3/31/2014

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	221,963	18,520	6,489	246,972		246,972		246,972			1
2	Food Purchase		170,092		170,092		170,092	(1,134)	168,958			2
3	Housekeeping	91,816	29,350		121,166		121,166		121,166			3
4	Laundry	47,415	20,886		68,301		68,301		68,301			4
5	Heat and Other Utilities			105,390	105,390		105,390		105,390			5
6	Maintenance	75,752	17,589	53,661	147,002		147,002		147,002			6
7	Other (specify):*											7
8	**TOTAL General Services**	436,946	256,437	165,540	858,923		858,923	(1,134)	857,789			8
	B. Health Care and Programs											
9	Medical Director			18,250	18,250		18,250		18,250			9
10	Nursing and Medical Records	1,378,145	121,838	7,293	1,507,276		1,507,276		1,507,276			10
10a	Therapy			432,116	432,116		432,116		432,116			10a
11	Activities	77,239	864		78,103		78,103		78,103			11
12	Social Services	39,381			39,381		39,381		39,381			12
13	CNA Training											13
14	Program Transportation			1,915	1,915		1,915		1,915			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,494,765	122,702	459,574	2,077,041		2,077,041		2,077,041			16
	C. General Administration											
17	Administrative	92,507			92,507		92,507		92,507			17
18	Directors Fees							3,516	3,516			18
19	Professional Services			376,621	376,621		376,621	6,318	382,939			19
20	Dues, Fees, Subscriptions & Promotions			14,402	14,402		14,402	4	14,406			20
21	Clerical & General Office Expenses	62,048	15,291	43,043	120,382		120,382		120,382			21
22	Employee Benefits & Payroll Taxes			316,739	316,739		316,739	5	316,744			22
23	Inservice Training & Education			4,313	4,313		4,313		4,313			23
24	Travel and Seminar			1,938	1,938		1,938		1,938			24
25	Other Admin. Staff Transportation			1,827	1,827		1,827		1,827			25
26	Insurance-Prop.Liab.Malpractice			106,702	106,702		106,702	1,965	108,667			26
27	Other (specify):*											27
28	**TOTAL General Administration**	154,555	15,291	865,585	1,035,431		1,035,431	11,808	1,047,239			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,086,266	394,430	1,490,699	3,971,395		3,971,395	10,674	3,982,069			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 Freeport Rehab & Health #0049155 **Report Period Beginning:** 4/1/2013 **Ending:** 3/31/2014

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			165,924	165,924		165,924		165,924			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			213,470	213,470		213,470	(26,516)	186,954			32
33	Real Estate Taxes			(223,840)	(223,840)		(223,840)		(223,840)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,426	4,426		4,426		4,426			35
36	Other (specify):*											36
37	**TOTAL Ownership**			159,980	159,980		159,980	(26,516)	133,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,498	3,498		3,498		3,498			38
39	Ancillary Service Centers		125,707		125,707		125,707		125,707			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,578	182,578		182,578		182,578			42
43	Other (specify):* See Att Sch III			81,808	81,808		81,808	(68,602)	13,206			43
44	**TOTAL Special Cost Centers**		125,707	267,884	393,591		393,591	(68,602)	324,989			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,086,266	520,137	1,918,563	4,524,966		4,524,966	(84,444)	4,440,522			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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	(1,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,320)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(26,516)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,532)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,692)	43		24
25	Fund Raising, Advertising and Promotional	(45,038)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,252)		$	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)	11,808		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 11,808		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,444)		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

Freeport Rehab & Health

ID# 0049155

Report Period Beginning: 4/1/2013

Ending: 3/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Freeport Rehab & Health # 0049155 **Report Period Beginning:** 4/1/2013 **Ending:** 3/31/2014

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	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	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**	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	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	3,516	0	0	0	0	0	0	0	0	0	3,516	18
19	Professional Services	0	6,318	0	0	0	0	0	0	0	0	0	6,318	19
20	Fees, Subscriptions & Promotions	0	4	0	0	0	0	0	0	0	0	0	4	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	5	0	0	0	0	0	0	0	0	0	5	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	1,965	0	0	0	0	0	0	0	0	0	1,965	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	11,808	0	0	0	0	0	0	0	0	0	11,808	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,134)	11,808	0	0	0	0	0	0	0	0	0	10,674	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Freeport Rehab & Health # 0049155 **Report Period Beginning:** 4/1/2013 **Ending:** 3/31/2014

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,516)	0	0	0	0	0	0	0	0	0	0	(26,516)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,516)	0	0	0	0	0	0	0	0	0	0	(26,516)	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):*	(68,602)	0	0	0	0	0	0	0	0	0	0	(68,602)	43
44	**TOTAL Special Cost Centers**	(68,602)	0	0	0	0	0	0	0	0	0	0	(68,602)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,252)	11,808	0	0	0	0	0	0	0	0	0	(84,444)	45

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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
Residential Alternatives of Illinois, Inc.	100	Frances House, Inc. (FH)				
(Non-profit Organization)		Residential Alternatives of Illinois, Inc. (FH is sole member)		See Attached Schedule I		
		Residential Alternatives of Iowa				
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Concepts Plus, Inc. (FH is sole member)				
		See Attached Schedule I for specific homes				

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	18	Director Fees	$	Residential Alternatives of Illinois, Inc.	100.00%	$ 3,516	$ 3,516	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	6,318	6,318	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	4	4	3
4	V	22	Employee Benefits & PR Taxes		Residential Alternatives of Illinois, Inc.	100.00%	5	5	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,965	1,965	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			$			$ 11,808	$ * 11,808	14

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	
	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	See Attached Schedule II								$ 3,516	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,516		13

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

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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 [X] NO [ ]

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

Name of Related Organization: Residential Alternatives of Illinois, Inc.
Street Address: 285 S. Farnham
City / State / Zip Code: Galesburg, IL 61401
Phone Number: (309) 343-1550
Fax Number: (309) 343-2857

	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	18	Director Fees	Weighted Avg Beds	876	16	30,200		102	$ 3,516	1
2	19	Professional Services	Weighted Avg Beds	876	16	54,254		102	6,318	2
3	20	Dues, Fees & Subscriptions	Weighted Avg Beds	876	16	35		102	4	3
4	22	Employee Benefits & PR Taxes	Weighted Avg Beds	876	16	43		102	5	4
5	26	Property Insurance	Weighted Avg Beds	876	16	16,880		102	1,965	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					$ 101,412	$		$ 11,808	25

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Frances House, Inc.	X		Facility Purchase	$25,918.73	01/31/08	$ 4,022,766	$ 3,504,503	02/28/2033	6.0000	$ 213,470	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$25,918.73		$ 4,022,766	$ 3,504,503			$ 213,470	9
	B. Non-Facility Related*											
10												10
11												11
12									Interest Income offset		(26,516)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,516)	14
15	TOTALS (line 9+line14)						$ 4,022,766	$ 3,504,503			$ 186,954	15

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

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

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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.**		$ 401,508	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.)		2012	$	2
3. Under or (over) accrual (line 2 minus line 1).			$ (401,508)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			$ 168,709	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.)		See Below	$ 8,959	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.			$ (223,840)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	N/A	8
	2010	N/A	9
	2011	N/A	10
	2012	N/A	11
	2013	131,159	12

This facility was purchased from an unrelated entity in January 2008. A tax exemption has been denied and the initial tax bill has been received for 2013. The accrual has been adjusted to include 12 months of 2013 and 3 months of 2014.

The $8,959 of appeal costs are legal expenses related to the tax assessment. Invoices are attached.

	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 Freeport Rehab & Health COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0049155

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 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.	18-13-34-477-001	PT SE SE SEC 34-27-7	$ 131,159.14	$ 131,159.14
2.		900 Kiwanis Dr	$	$
3.		Freeport, IL 61032	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 131,159.14	$ 131,159.14

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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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: _____

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	Facility	5 acres	2008	$ 86,000	1
2					2
3	TOTALS	#VALUE!		$ 86,000	3

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	143		2008		$ 3,159,500	$ 126,369	25	$ 126,369	$	$ 779,344	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cable System/Boiler/Bathrm Remodel/Parkg Lot Blacktop			2008	206,560	10,475	5-20 yrs	10,475		65,372	9
10	Roof Top Heating and Air Unit			2009	5,436	544	10	544		2,537	10
11	Emergency Generator			2010	34,927	1,744	20	1,744		7,276	11
12	Water Heater			2010	3,480	348	10	348		1,450	12
13	Tilt/Slide End Vent Windows			2010	7,789	519	15	519		2,077	13
14	Water Heater			2011	4,165	415	10	415		972	14
15	Metal Door and Frame			2012	6,873	342	20	342		716	15
16	Fire Alarm System			2012	92,490	9,249	10	9,249		18,498	16
17	Dialysis Room-Laminate/Plumbing/Vct Tile/Cove Base/Drywall/Medicine			2013	13,632	1,136	12	1,136		1,231	17
18	Exhaust Fans and Duct work in lower level/First Floor/Oxygen Room			2012	19,476	974	20	974		1,542	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,554,328	$ 152,115		$ 152,115	$	$ 881,015	70

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	$ 751,281	$ 13,196	$ 13,196	$	5-15 yrs	$ 675,324	71
72	Current Year Purchases	9,811	613	613		16 yrs	613	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 761,092	$ 13,809	$ 13,809	$		$ 675,937	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	Patient Care	2005 Ford Ecoline	2008	$ 27,000	$	$	$	4	$ 27,000	76
77										77
78										78
79										79
80	TOTALS			$ 27,000	$	$	$		$ 27,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,428,420	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,924	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 165,924	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,583,952	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1994 Dodge Station Wagon - 2008	$ 3,000	$	$ 3,000	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 3,000	$	$ 3,000	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 3,384	92
93			93
94			94
95		$ 3,384	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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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 ☐ 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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 4,426 Description: See Attached Schedule V
    (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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	10A(3)	hrs	$	9,739	$ 175,301	$	9,739	$ 175,301	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,255	40,597		2,255	40,597	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,395	205,104		11,395	205,104	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				125,707		125,707	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(3)			617	11,114		617	11,114	12
13	Other (specify):									13
14	TOTAL			$	24,006	$ 432,116	$ 125,707	24,006	$ 557,823	14

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/2014 (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	$ 45,499	$ 45,499	1
2	Cash-Patient Deposits	12,855	12,855	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 22,000)	861,274	861,274	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,558	39,558	6
7	Other Prepaid Expenses	3,648	3,648	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 962,834	$ 962,834	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	86,000	86,000	13
14	Buildings, at Historical Cost	3,159,500	3,159,500	14
15	Leasehold Improvements, at Historical Cost	394,828	394,828	15
16	Equipment, at Historical Cost	791,092	788,092	16
17	Accumulated Depreciation (book methods)	(1,586,952)	(1,583,952)	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 **Constr in Progress**	3,384	3,384	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,847,852	$ 2,847,852	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,810,686	$ 3,810,686	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,092	$ 71,092	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,855	12,855	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,846	50,846	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,708	56,708	31
32	Accrued Real Estate Taxes(Sch.IX-B)	168,709	168,709	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Interdivision Payable**	3,344,000	3,344,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,704,210	$ 3,704,210	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,504,503	3,504,503	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Security Deposits**	16,500	16,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,521,003	$ 3,521,003	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,225,213	$ 7,225,213	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,414,527)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,810,686	$ 7,225,213	48

***(See instructions.)**

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,729,554)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,729,554)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(684,973)	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)**	$ (684,973)	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)**	$ (3,414,527)	24 *

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	$ 3,784,602	1
2	Discounts and Allowances for all Levels	(4,252)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,780,350	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	14,876	6
7	Oxygen	5,686	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,562	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	2,364	13
14	Non-Patient Meals	1,134	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	357	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,869	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,724	23
	D. Non-Operating Revenue		
24	Contributions	2,841	24
25	Interest and Other Investment Income***	26,516	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,357	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)**	$ 3,839,993	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	858,923	31
32	Health Care	2,077,041	32
33	General Administration	1,035,431	33
	B. Capital Expense		
34	Ownership	159,980	34
	C. Ancillary Expense		
35	Special Cost Centers	211,013	35
36	Provider Participation Fee	182,578	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,524,966	40
41	**Income before Income Taxes (line 30 minus line 40)****	(684,973)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (684,973)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,598,371	44
45	Private Pay - Net Inpatient Revenue	602,835	45
46	Medicare - Net Inpatient Revenue	1,299,722	46
47	Other-(specify) Medicare Replacement	279,422	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,780,350	49

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

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

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

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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	2,052	2,080	$ 65,399	$ 31.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,468	18,990	396,620	20.89	3
4	Licensed Practical Nurses	8,499	9,392	174,589	18.59	4
5	CNAs & Orderlies	57,167	61,326	668,672	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,269	6,631	77,239	11.65	10
11	Social Service Workers	1,883	2,105	39,381	18.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,322	20,449	221,963	10.85	15
16	Dishwashers					16
17	Maintenance Workers	3,871	4,150	75,752	18.25	17
18	Housekeepers	9,852	10,331	91,816	8.89	18
19	Laundry	5,386	5,639	47,415	8.41	19
20	Administrator	1,972	2,080	60,892	29.28	20
21	Assistant Administrator	2,103	2,151	31,615	14.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,282	5,580	62,048	11.12	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	2,019	2,179	23,407	10.74	31
32	Other Health C: MDS Coord	2,026	2,195	49,458	22.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,171	155,278	$ 2,086,266 *	$ 13.44	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	Monthly	$ 6,489	L1, C3	35
36	Medical Director	Monthly	18,250	L9, C3	36
37	Medical Records Consultant	Monthly	1,720	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,817	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,276		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Erica Sprenger	Administrator	None	$ 60,892
Dayna Troxel	Asst. Administrator	None	8,077
Courtney Pruitt	Asst. Administrator	None	23,538
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,507

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	$ 171,600
LTC Support Services, LLC	Support Services	181,200
McGladrey LLP	Accounting Services	19,999
Blue Orange	HIPPA Compliance Cons	1,072
Templin Healthcare Accounting	Accounting Services	251
Polsinelli Shughart PC	Legal Services	210
Anthony V Coon	Legal Services	2,289
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 376,621

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,517
Unemployment Compensation Insurance	(124)
FICA Taxes	155,629
Employee Health Insurance	67,160
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	12,120
Other Employee Benefits	4,437
Indirect costs	5
TOTAL (agree to Schedule V, line 22, col.8)	$ 316,744

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	$
Advertising: Employee Recruitment	3,567
Health Care Worker Background Check	
(Indicate # of checks performed 41)	1,041
Patient Background Checks 84	1,430
Subscriptions	651
IHCA Dues	5,362
Other Licenses & Fees	2,351
Indirect costs	4
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,406

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,938
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,938

**See instructions.

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2013 Ending: 3/31/2014

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? **Yes**
If YES, give association name and amount. **5,362 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes - IHCA Dues** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **16 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,954** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **182,578**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,134**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	221,963	18,520	6,489	246,972	0	246,972	0	246,972
2. Food Purchase	0	170,092	0	170,092	0	170,092	-1,134	168,958
3. Housekeeping	91,816	29,350	0	121,166	0	121,166	0	121,166
4. Laundry	47,415	20,886	0	68,301	0	68,301	0	68,301
5. Heat and Other Utilities	0	0	105,390	105,390	0	105,390	0	105,390
6. Maintenance	75,752	17,589	53,661	147,002	0	147,002	0	147,002
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	436,946	256,437	165,540	858,923	0	858,923	-1,134	857,789
9. Medical Director	0	0	18,250	18,250	0	18,250	0	18,250
10. Nursing & Medical Records	1,378,145	121,838	7,293	1,507,276	0	1,507,276	0	1,507,276
10a. Therapy	0	0	432,116	432,116	0	432,116	0	432,116
11. Activities	77,239	864	0	78,103	0	78,103	0	78,103
12. Social Services	39,381	0	0	39,381	0	39,381	0	39,381
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	1,915	1,915	0	1,915	0	1,915
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,494,765	122,702	459,574	2,077,041	0	2,077,041	0	2,077,041
17. Administrative	92,507	0	0	92,507	0	92,507	0	92,507
18. Directors Fees	0	0	0	0	0	0	3,516	3,516
19. Professional Services	0	0	376,621	376,621	0	376,621	6,318	382,939
20. Fees, Subscriptions & Promotion	0	0	14,402	14,402	0	14,402	4	14,406
21. Clerical & General Office	62,048	15,291	43,043	120,382	0	120,382	0	120,382
22. Employee Benefits & Payroll	0	0	316,739	316,739	0	316,739	5	316,744
23. Inservice Training & Education	0	0	4,313	4,313	0	4,313	0	4,313
24. Travel and Seminar	0	0	1,938	1,938	0	1,938	0	1,938
25. Other Admin. Staff Trans	0	0	1,827	1,827	0	1,827	0	1,827
26. Insurance-Prop.Liab.Malpractice	0	0	106,702	106,702	0	106,702	1,965	108,667
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	154,555	15,291	865,585	1,035,431	0	1,035,431	11,808	1,047,239
29. Total General Administrative	2,086,266	394,430	1,490,699	3,971,395	0	3,971,395	10,674	3,982,069
30. Depreciation	0	0	165,924	165,924	0	165,924	0	165,924
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	213,470	213,470	0	213,470	-26,516	186,954
33. Real Estate	0	0	-223,840	-223,840	0	-223,840	0	-223,840

34.	Rent - Facility & Grounds		0	0	0	0	0	0	0	0
35.	Rent - Equipment & Vehicles		0	0	4,426	4,426	0	4,426	0	4,426
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	159,980	159,980	0	159,980	-26,516	133,464
38.	Medically Necessary T		0	0	3,498	3,498	0	3,498	0	3,498
39.	Ancillary Service Cent		0	125,707	0	125,707	0	125,707	0	125,707
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	182,578	182,578	0	182,578	0	182,578
43.	Other (specify):*		0	0	81,808	81,808	0	81,808	-68,602	13,206
44.	Total Special Cost Ce		0	125,707	267,884	393,591	0	393,591	-68,602	324,989
45.	Grand Total		2,086,266	520,137	1,918,563	4,524,966	0	4,524,966	-84,444	4,440,522

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	45,499	45,499
2. Cash - Patient Deposits	12,855	12,855
3. Accounts & Notes Recievable	861,274	861,274
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	39,558	39,558
7. Other Prepaid Expenses	3,648	3,648
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	962,834	962,834
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	86,000	86,000
14. Buildings, at Historical Cost	3,159,500	3,159,500
15. Leasehold Improvements, Historical Cost	394,828	394,828
16. Equipment, at Historical Cost	791,092	788,092
17. Accumulated Depreciation (book methods)	-1,586,952	-1,583,952
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	3,384	3,384
23. other (specify):	0	0
24. Total Long-Term Assets	2,847,852	2,847,852
25. Total Assets	3,810,686	3,810,686
CURRENT LIABILITIES		
26. Accounts Payable	71,092	71,092
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	12,855	12,855
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	50,846	50,846
31. Accrued Taxes Payable	56,708	56,708
32. Accrued Real Estate Taxes	168,709	168,709
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	3,344,000	3,344,000

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	3,704,210	3,704,210
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,504,503	3,504,503
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	16,500	16,500
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,521,003	3,521,003
46.Total Liabilities	7,225,213	7,225,213
47.Total Equity	-3,414,527	-3,414,527
48.Total Liabilities and Equity	3,810,686	3,810,686

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,784,602
2. Discounts and Allowances for all Levels	-4,252
Subtotal - Inpatient Care	3,780,350
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	14,876
7. Oxygen	5,686
Subtotal - Anciliary Revenue	20,562
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	2,364
14. Non-Patient Meals	1,134
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	357
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	5,869
22. Laundry	0
Subtotal - Other Operating Revenue	9,724
24. Contributions	2,841
25. Interest and Other Investments Income	26,516
Subtotal - Non-Operating Revenue	29,357
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	3,839,993
31. General Services	858,923
32. Health Care	2,078,641
33. General Administration	1,033,831
34. Ownership	159,980

35.	Special Cost Centers	211,013
35.	Provider Participation Fee	182,578
37.	Other	0
40.	Total Expenses	4,524,966
41.	Income Before Income Taxes	-684,973
42.	Income Taxes	0
43.	Net Income or Loss for the Year	-684,973