FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0049155

Facility Name: Freeport Rehab & Health

Address: 900 South 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: 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 4/1/2014 to 3/31/2015 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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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 07/01/2014

	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)	109	42,879	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	109	42,879	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	11,863	4,164	3,691	19,718	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,863	4,164	3,691	19,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.99%

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 [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 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 2,592

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: 03/31/15 Fiscal Year: 03/31/15

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

Facility Name: **Freeport Rehab & Health**
IDPH License ID Number: **0049155**
Fiscal Year End: **3/31/2015**

Schedule 2A

III. Statistical Data
Bed Days Computation

Licensure Level of Care	# of Beds	Start Date	End Date	# of Days	Bed Days Available
Skilled (SNF)	143	4/1/14	6/30/14	91	13,013
Skilled (SNF)	109	7/1/14	3/31/15	274	29,866
			Total - Line 1, Column 4		42,879

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	204,172	16,647	6,144	226,964		226,964		226,964			1
2	Food Purchase		160,686		160,686		160,686	(525)	160,161			2
3	Housekeeping	71,461	17,545		89,005		89,005		89,005			3
4	Laundry	46,122	23,342		69,464		69,464		69,464			4
5	Heat and Other Utilities			98,781	98,781		98,781		98,781			5
6	Maintenance	94,156	13,260	72,120	179,536		179,536		179,536			6
7	Other (specify):*											7
8	**TOTAL General Services**	415,911	231,480	177,045	824,436		824,436	(525)	823,911			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,266,448	80,399	5,431	1,352,278		1,352,278		1,352,278			10
10a	Therapy											10a
11	Activities	83,757	754		84,511		84,511		84,511			11
12	Social Services	21,771			21,771		21,771		21,771			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,371,976	81,152	29,431	1,482,559		1,482,559		1,482,559			16
	C. General Administration											
17	Administrative	96,753			96,753		96,753		96,753			17
18	Directors Fees							3,995	3,995			18
19	Professional Services			389,760	389,760		389,760	7,370	397,130			19
20	Dues, Fees, Subscriptions & Promotions			14,368	14,368		14,368	(2,508)	11,860			20
21	Clerical & General Office Expenses	62,026	6,558	39,931	108,516		108,516	(1,132)	107,384			21
22	Employee Benefits & Payroll Taxes			338,586	338,586		338,586	3	338,589			22
23	Inservice Training & Education			8,293	8,293		8,293		8,293			23
24	Travel and Seminar			1,326	1,326		1,326		1,326			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			115,850	115,850		115,850	4,351	120,201			26
27	Other (specify):*											27
28	**TOTAL General Administration**	158,779	6,558	908,113	1,073,450		1,073,450	12,079	1,085,529			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,946,665	319,191	1,114,589	3,380,446		3,380,446	11,554	3,392,000			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:** 4/1/2014 **Ending:** 3/31/2015

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			163,810	163,810		163,810	(7)	163,803			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			207,453	207,453		207,453	(10,673)	196,780			32
33	Real Estate Taxes			137,160	137,160		137,160	9,031	146,191			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,582	2,582		2,582		2,582			35
36	Other (specify):*											36
37	**TOTAL Ownership**			511,004	511,004		511,004	(1,649)	509,355			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,569	390,029	533,598		533,598	(2,219)	531,379			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,107	168,107		168,107		168,107			42
43	Other (specify):* Non-Allowable Cos			206,259	206,259		206,259	(206,259)	(0)			43
44	**TOTAL Special Cost Centers**		143,569	764,394	907,963		907,963	(208,478)	699,485			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,946,665	462,760	2,389,988	4,799,414		4,799,414	(198,573)	4,600,841			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: 4/1/2014 Ending: 3/31/2015

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	(525)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,536)	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	(7)	30		9
10	Interest and Other Investment Income	(10,673)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,286)	43		24
25	Fund Raising, Advertising and Promotional	(49,859)	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 Pg 5A	(3,438)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (214,324)		$	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)	15,751		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 15,751		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (198,573)		37

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

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

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

Freeport Rehab & Health

ID# 0049155

Report Period Beginning: 4/1/2014

Ending: 3/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Part A Lab	$ (4,445)	43	1
2	Medicare Part A X-Ray	(1,450)	43	2
3	Outpatient Medicare	(754)	43	3
4	Collection Fees	93	43	4
5	Managed Care	(22)	43	5
6	Offset lobbying expense	(2,540)	30	6
7	Offset oxygen revenue	(2,219)	39	7
8	Offset miscellaneous income	(1,132)	21	8
9	Real Estate Taxes	9,031	33	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
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26				26
27				27
28				28
29				29
30				30
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32				32

33				33
34				34
35				35
36				36
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,438)		49

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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 Page 6 Supplemental		
		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 Page 6 Supplemental 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%	$ 3,995	$ 3,995	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	7,370	7,370	2
3	V	21	Bank Fees		Residential Alternatives of Illinois, Inc.	100.00%	32	32	3
4	V	22	Employee Benefits & PR Taxes		Residential Alternatives of Illinois, Inc.	100.00%	3	3	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	4,351	4,351	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			$			$ 15,751	$ * 15,751	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: 4/1/2014 Ending: 3/31/2015

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	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville	IL			Skilled Nursing Faci	1
2	Residential Alternatives of Illinois	100%	Manor Court of Clinton	Clinton	IL			Skilled Nrsg & Supp	2
3	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport	IL			Skilled Nursing Faci	3
4	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria	IL			Skilled Nursing Faci	4
5	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru	IL			Skilled Nursing Faci	5
6	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton	IL			Skilled Nrsg Fac & S	6
7	Residential Alternatives of Illinois	100%				Hawthorne Inn of Free	Freeport, IL	Supportive Living F	7
8	Residential Alternatives of Illinois	100%				Hawthorne Inn of Peor	Peoria, IL	Assisted Living Faci	8
9	Residential Alternatives of Illinois	100%				Hawthorne Inn of Peru	Peru, IL	Assisted Living Faci	9
10	Residential Alternatives of Illinois	100%				Liberty Estates of Gen	Geneseo, IL	Asst'd & Ind Living	10
11	Residential Alternatives of Illinois	100%				Liberty Estates of Stre	Streator, IL	Asst'd & Ind Living	11
12	Residential Alternatives of Illinois	100%	Freeport Rehab & Healthcare	Freeport	IL			Skilled Nursing Faci	12
13	Residential Alternatives of Illinois	100%				Liberty Estates of Dan	Danville, IL	Indendent Living Fa	13
14	Residential Alternatives of Illinois	100%				Liberty Estates of Free	Freeport, IL	Indendent Living Fa	14
15	Residential Alternatives of Illinois	100%				Liberty Estates of Peor	Peoria, IL	Indendent Living Fa	15
16	Residential Alternatives of Illinois	100%				Liberty Estates of Peru	Peru, IL	Indendent Living Fa	16
17	Residential Alternatives of Iowa	100%		Coralville	IA			Long-term Care Fac	17
18	Frances House, Inc.	100%				Casa Willis	Sterling, IL	DD Facilities	18
19	Frances House, Inc.	100%				Freeport Terrace	Freeport, IL	DD Facilities	19
20	Frances House, Inc.	100%				Gordon Jones Terrace	Lanark, IL	DD Facilities	20
21	Frances House, Inc.	100%				Hallam Terrace	Rockford, IL	DD Facilities	21
22	Frances House, Inc.	100%				Hammett House	Sterling, IL	DD Facilities	22
23	Frances House, Inc.	100%				Kanthak House	Ottawa, IL	DD Facilities	23
24	Frances House, Inc.	100%				Olson Terrace	Rockford, IL	DD Facilities	24
25	Frances House, Inc.	100%				Ridge Terrace	Freeport, IL	DD Facilities	25
26	Frances House, Inc.	100%				Cantebury Place	Rockford, IL	DD Facilities	26
27	Frances House, Inc.	100%				Glenwood Villa	Rockford, IL	DD Facilities	27
28	Frances House, Inc.	100%				Rockton Court	Rockford, IL	DD Facilities	28
29	Frances House, Inc.	100%				Rose House	Moline, IL	DD Facilities	29
30	Frances House, Inc.	100%				Seborg Terrace	Rockford, IL	DD Facilities	30

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	Frances House, Inc.	100%			Smith Square	Moline, IL	DD Facility	1
2	Frances House, Inc.	100%			Stern Square	Sterling, IL	DD Facility	2
3	Frances House, Inc.	100%			Stouffer Terrace	Oregon, IL	DD Facility	3
4	Frances House, Inc.	100%			Lewis Terrace	North Chicago, Il	Group Home	4
5	Frances House, Inc.	100%			Seymour Terrace	North Chicago, Il	Group Home	5
6	Frances House, Inc.	100%			Waukegan Terrace	Waukegan, IL	Group Home	6
7	Frances House, Inc.	100%			Pine Terrace	Waukegan, IL	Group Home	7
8	Frances House, Inc.	100%			Peoria Manor Court	Galesburg, IL	Real Estate Entity	8
9	Frances House, Inc.	100%			Peru Becker, Ltd., NFI	Galesburg, IL	Real Estate Entity	9
10	Frances House, Inc.	100%			Danville Independence	Galesburg, IL	Real Estate Entity	10
11	Frances House, Inc.	100%			Hawthorne Inn of Prir	Galesburg, IL	Real Estate Entity	11
12	Pioneer Concepts, Inc.	100%			Broadway Terrace	Chicago Heights, IL	DD Facility	12
13	Pioneer Concepts, Inc.	100%			Carole Lane Terrace	Sauk Village, IL	DD Facility	13
14	Pioneer Concepts, Inc.	100%			Flossmoor Terrace	Flossmoor, IL	DD Facility	14
15	Pioneer Concepts, Inc.	100%			Ravisloe Terrace	Country Club Hills, IL	DD Facility	15
16	Pioneer Concepts, Inc.	100%			Spaulding Terrace	Markham, IL	DD Facility	16
17	Pioneer Concepts, Inc.	100%			Calumet City Terrace	Calumet City, IL	DD Facility	17
18	Pioneer Concepts, Inc.	100%			Dolton Terrace	Dolton, IL	DD Facility	18
19	Pioneer Concepts, Inc.	100%			Lynwood Terrace	Lynwood, IL	DD Facility	19
20	Pioneer Concepts, Inc.	100%			Holland Terrace	South Holland, IL	DD Facility	20
21	Pioneer Concepts, Inc.	100%			Matteson Court	Matteson, IL	DD Facility	21
22	Pioneer Concepts, Inc.	100%			Priarie House	Sauk Village, IL	DD Facility	22
23	Pioneer Concepts, Inc.	100%			Torrence Place	Sauk Village, IL	DD Facility	23
24	Pinnacle Opportunities	100%			Chambness Square	Bourbannais, IL	DD Facility	24
25	Pinnacle Opportunities	100%			Collins Square	Bradley, IL	DD Facility	25
26	Pinnacle Opportunities	100%			Dearborn Court	Kankakee, IL	DD Facility	26
27	Pinnacle Opportunities	100%			River Court	Kankakee, IL	DD Facility	27
28	Pinnacle Opportunities	100%			Station Court	Kankakee, IL	DD Facility	28
29	Pinnacle Opportunities	100%			Eagle Court	Kankakee, IL	DD Facility	29
30	Pinnacle Opportunities	100%			Kankakee Court	Kankakee, IL	DD Facility	30

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	Pinnacle Opportunities	100%			Roy Court	Bourbannais, IL	DD Facility	1
2	Pinnacle Opportunities	100%			Gravlin Square	Bradley, IL	DD Facility	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	Irwin Jann	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	$ 841	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	631	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	841	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	841	L18, C7	4
5	John Kniery	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	841	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	$ 3,995		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: 4/1/2014 Ending: 3/31/2015

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	308,225	17	$ 28,715	$	42,879	$ 3,995	1
2	19	Professional Services	Weighted Avg Beds	308,225	17	52,978		42,879	7,370	2
3	21	Bank Fees	Weighted Avg Beds	308,225	17	233		42,879	32	3
4	22	Employee Benefits & PR Taxes	Weighted Avg Beds	308,225	17	25		42,879	3	4
5	26	Property Insurance	Weighted Avg Beds	308,225	17	31,275		42,879	4,351	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					$ 113,226	$		$ 15,751	25

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	Frances House, Inc.	X		Facility Purchase	$25,918.73	01/31/08	$ 4,022,766	$ 3,400,931	02/28/2033	6.00	$ 207,453	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	$ 3,400,931			$ 207,453	9
	B. Non-Facility Related*											
10												10
11								Offset Interest Income			(10,673)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,673)	14
15	TOTALS (line 9+line14)						$ 4,022,766	$ 3,400,931			$ 196,780	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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 168,709	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	$ 140,190	2
3. Under or (over) accrual (line 2 minus line 1).		$ (28,519)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 165,679	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.		$ 137,160	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	N/A	8
	2011	N/A	9
	2012	N/A	10
	2013	131,159	11
	2014	132,952	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.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 132,951.56	$ 132,951.56
2.		900 Kiwanis Dr	$	$
3.		Freeport, IL 61032	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 132,951.56	$ 132,951.56

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 4/1/2014 Ending: 3/31/2015

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. [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).

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: 4/1/2014 Ending: 3/31/2015

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	$	$ 905,713	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cable System/Boiler/Bathrm Remodel/Parkg Lot Blacktop			2008	206,560	10,394	5-20 yrs	10,394		75,766	9
10	Roof Top Heating and Air Unit			2009	5,436	544	10	544		3,081	10
11	Emergency Generator			2010	34,927	1,746	20	1,746		9,022	11
12	Water Heater			2010	3,480	348	10	348		1,798	12
13	Tilt/Slide End Vent Windows			2010	7,789	519	15	519		2,596	13
14	Water Heater			2011	4,165	417	10	417		1,389	14
15	Metal Door and Frame			2012	6,873	344	20	344		1,060	15
16	Fire Alarm System			2012	92,490	9,249	10	9,249		27,747	16
17	Dialysis Room-Laminate/Plumbing/Vct Tile/Cove Base/Drywall/Medicine			2013	13,632	1,138	12	1,138		2,369	17
18	Exhaust Fans and Duct work in lower level/First Floor/Oxygen Room			2012	19,476	974	20	974		2,516	18
19											19
20	To tie to financial statements					7			(7)		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: 4/1/2014 Ending: 3/31/2015

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	$ 152,049		$ 152,042	$ (7)	$ 1,033,057	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: 4/1/2014 Ending: 3/31/2015

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	$ 131,536	$ 11,761	$ 11,761	$	5-15	$ 58,142	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	629,556					629,556	73
74								74
75	TOTALS	$ 761,092	$ 11,761	$ 11,761	$		$ 687,698	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 Econoline	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)	$ 163,810	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 163,803	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,747,755	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	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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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:	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. 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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 2582.00 Description: Wound Therapy - $1,997, Bipap - $390, Vpap - $195
    (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 & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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: 4/1/2014 Ending: 3/31/2015

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	$	2,057	$ 148,083	$	2,057	$ 148,083	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		478	34,450		478	34,450	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,394	172,401		2,394	172,401	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				135,866		135,866	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapy & Oxyg	39(2 & 3)			221	15,897	7,703	221	23,600	12
13	Other (specify): Ambulance	39(3)			267	19,199		267	19,199	13
14	TOTAL			$	5,417	$ 390,030	$ 143,569	5,417	$ 533,599	14

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

STATE OF ILLINOIS

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/2015 (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	$ 13,159	$ 13,159	1
2	Cash-Patient Deposits	13,594	13,594	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,800)	881,413	881,413	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,556	40,556	6
7	Other Prepaid Expenses	1,656	1,656	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Receivable for Cost Report	38,361	38,361	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 988,739	$ 988,739	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)	(1,750,762)	(1,747,755)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,680,658	$ 2,680,665	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,669,397	$ 3,669,404	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,530	$ 49,530	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,594	13,594	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	7,866	7,866	31
32	Accrued Real Estate Taxes(Sch.IX-B)	165,679	165,679	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Utilities Payable	8,321	8,321	36
37	See Attached Sch 17A	108,597	108,597	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 353,588	$ 353,588	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Sch 17A	4,343,324	4,343,324	43
44	InterCo Advance	3,400,931	3,400,931	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,744,255	$ 7,744,255	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,097,843	$ 8,097,843	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,428,446)	$ (4,428,439)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,669,397	$ 3,669,404	48

***(See instructions.)**

Facility Name: **Freeport Rehab & Health**
IDPH License ID Number: **0049155**
Fiscal Year End: **3/31/2015**

Schedule 17A

XV. Balance Sheet
XV. Balance Sheet
Line 37 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accts Rec - Estates	23,364	23,364
Accrued Employee Time	42,169	42,169
Accrued Medicaid Assess Tax	76	76
Provider Tax Act	42,988	42,988
Total - Line 37	**108,597**	**108,597**

XV. Balance Sheet
Line 43 Other Long-Term Liabilities (specify):

Description	Operating	After Consolidation
Inter-Co Freeport Rehab	4,323,824	4,323,824
Security Dep - No Interest	19,500	19,500
Total - Line 43	**4,343,324**	**4,343,324**

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,414,527)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,414,527)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,013,919)	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)**	$ (1,013,919)	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)**	$ (4,428,446)	24	*

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	$ 3,723,149	1
2	Discounts and Allowances for all Levels	(26,852)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,696,297	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,925	6
7	Oxygen	2,219	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 15,144	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	2,615	13
14	Non-Patient Meals	525	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	53,356	16
17	Sale of Drugs	2,115	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,690	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,301	23
	D. Non-Operating Revenue		
24	Contributions	348	24
25	Interest and Other Investment Income***	10,673	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,022	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fee Income	1,599	28
28a	Miscellaneous Income	1,132	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,731	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,785,495	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	824,436	31
32	Health Care	1,482,559	32
33	General Administration	1,073,450	33
	B. Capital Expense		
34	Ownership	511,004	34
	C. Ancillary Expense		
35	Special Cost Centers	739,856	35
36	Provider Participation Fee	168,107	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,799,414	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,013,919)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,013,919)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,627,930	44
45	Private Pay - Net Inpatient Revenue	711,520	45
46	Medicare - Net Inpatient Revenue	1,096,770	46
47	Other-(specify) Medicare Replacement	245,694	47
48	Other-(specify) Managed Care	14,383	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,696,297	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.**

^ - This entity is a cash basis taxpayer

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	1,968	2,000	$ 53,301	$ 26.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,542	14,103	324,013	22.97	3
4	Licensed Practical Nurses	9,844	10,367	212,901	20.54	4
5	CNAs & Orderlies	50,680	53,470	593,750	11.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,361	7,610	83,757	11.01	10
11	Social Service Workers	1,328	1,368	21,771	15.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,673	18,641	204,172	10.95	15
16	Dishwashers					16
17	Maintenance Workers	7,399	7,715	94,156	12.20	17
18	Housekeepers	5,828	6,241	71,461	11.45	18
19	Laundry	4,985	5,346	46,122	8.63	19
20	Administrator	1,808	2,012	62,897	31.26	20
21	Assistant Administrator	2,087	2,166	33,856	15.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,275	5,574	62,026	11.13	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	1,922	2,110	22,329	10.58	31
32	Other Health C: MDS Coord	2,633	2,877	60,153	20.91	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,333	141,600	$ 1,946,665 *	$ 13.75	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	$ 6,144	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,480	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,951	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)		$ 35,575		49

C. CONTRACT NURSES

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

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Erica Sprenger	Administrator	None	$ 30,347
Lori Steele	Administrator	None	32,550
Jessica Ernst	Asst. Administrator	None	29,823
Courtney Pruitt	Asst. Administrator	None	4,033
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,753

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	198,581
McGladrey LLP	Accounting Services	15,356
Templin Healthcare Accounting	Accounting Services	4,223
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 389,760

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,272
Unemployment Compensation Insurance	7,368
FICA Taxes	144,538
Employee Health Insurance	100,676
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	12,467
Other Employement Expense	2,382
Employee Appreciation	2,886
TOTAL (agree to Schedule V, line 22, col.8)	$ 338,589

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	1,757
Health Care Worker Background Check	
(Indicate # of checks performed 105)	1,258
Patient Background Checks 105	1,258
Misc Licenses & Fees	2,493
Misc Dues & Subscriptions	985
IHCA Dues	6,617
Less : Lobbying Expense	(2,540)
Allocated from Home Office	32
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,860

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,326
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,326

**See instructions.

Facility Name: **Freeport Rehab & Health**
IDPH License ID Number: **0047134**
Fiscal Year End: **3/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
	Total (agree to Schedule V, line 19, column 3)	389,760
	Allocated from Management Company Professional Services	7,370
	Total (agree to Schedule V, line 19, column 8)	397,130

Facility Name & ID Number Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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 Freeport Rehab & Health # 0049155 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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. **IHCA - $6,617**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,556** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **168,107**
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. $ **525**

(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? **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? **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 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.