

Facility Name & ID Number Freeburg Care Center

0025098 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,319	3,000	4,099	8,418	8
9	SNF/PED					9
10	ICF	10,119	17,140		27,259	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,438	20,140	4,099	35,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.83%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 4,099

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	282,311	8,043	8,242	298,596		298,596		298,596		1
2	Food Purchase		242,212		242,212		242,212	(4,299)	237,913		2
3	Housekeeping	202,644	17,970		220,614		220,614		220,614		3
4	Laundry	73,240	33,531		106,771		106,771		106,771		4
5	Heat and Other Utilities			140,488	140,488		140,488		140,488		5
6	Maintenance	98,201	21,865	66,772	186,838		186,838		186,838		6
7	Other (specify):* Waste Removal			8,827	8,827		8,827		8,827		7
8	TOTAL General Services	656,396	323,621	224,329	1,204,346		1,204,346	(4,299)	1,200,047		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,094,575	95,242	293,596	2,483,413		2,483,413		2,483,413		10
10a	Therapy										10a
11	Activities	77,621	9,762	14,595	101,978		101,978	(1,081)	100,897		11
12	Social Services	45,769		1,992	47,761		47,761		47,761		12
13	CNA Training										13
14	Program Transportation			1,630	1,630		1,630		1,630		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,217,965	105,004	326,213	2,649,182		2,649,182	(1,081)	2,648,101		16
	C. General Administration										
17	Administrative	117,540			117,540		117,540		117,540		17
18	Directors Fees			11,600	11,600		11,600		11,600		18
19	Professional Services			107,426	107,426		107,426	400	107,826		19
20	Dues, Fees, Subscriptions & Promotions			8,987	8,987		8,987	(61)	8,926		20
21	Clerical & General Office Expenses	133,544	46,146	16,823	196,513		196,513	(255)	196,258		21
22	Employee Benefits & Payroll Taxes			369,143	369,143		369,143		369,143		22
23	Inservice Training & Education			433	433		433		433		23
24	Travel and Seminar			205	205		205		205		24
25	Other Admin. Staff Transportation			1,836	1,836		1,836		1,836		25
26	Insurance-Prop.Liab.Malpractice			96,930	96,930		96,930		96,930		26
27	Other (specify):*										27
28	TOTAL General Administration	251,084	46,146	613,383	910,613		910,613	84	910,697		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,125,445	474,771	1,163,925	4,764,141		4,764,141	(5,296)	4,758,845		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Freeburg Care Center

#0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			54,567	54,567		54,567	18,846	73,413		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			11,239	11,239		11,239	6,790	18,029		32
33	Real Estate Taxes			57,246	57,246		57,246		57,246		33
34	Rent-Facility & Grounds			162,979	162,979		162,979	(162,979)			34
35	Rent-Equipment & Vehicles			16,428	16,428		16,428		16,428		35
36	Other (specify):*										36
37	TOTAL Ownership			302,459	302,459		302,459	(137,343)	165,116		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		96,763	815,641	912,404		912,404		912,404		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			257,569	257,569		257,569		257,569		42
43	Other (specify):* Disallowed Costs	48,852		598,314	647,166		647,166	(638,525)	8,641		43
44	TOTAL Special Cost Centers	48,852	96,763	1,671,524	1,817,139		1,817,139	(638,525)	1,178,614		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,174,297	571,534	3,137,908	6,883,739		6,883,739	(781,164)	6,102,575		45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Freeburg Care Center

Period Beginning
Period End

1/1/2017
12/31/2017

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0	0		0			
	Laboratory Expense			6,959	6,959	6,959		6,959			
	Radiology Expenses			1,682	1,682	1,682		1,682			
	Non-Allowable Expenses	48,852		589,673	638,525	638,525	(638,525)	0			
					0	0		0			
					0	0		0			
	TOTAL Other Special Cost Centers	48,852	0	598,314	647,166	647,166	(638,525)	8,641			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,469)	2		4
5	Telephone, TV & Radio in Resident Rooms	(575)	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	7,268	30		9
10	Interest and Other Investment Income	(672)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,022)	43		13
14	Non-Care Related Interest	(10,567)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	(35,653)	43		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	(540,048)	43		24
25	Fund Raising, Advertising and Promotional	(13,374)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,008)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(51,186)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (650,406)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(130,758)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (130,758)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (781,164)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Freeburg Care Center

ID# 0025098

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Offset Miscellaneous Income	\$ (423)	21	1
2	Offset Vending Income	(830)	2	2
3	Offset Activity Income Against Expense	(1,081)	11	3
4	Disallow Marketing Wages	(48,852)	43	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
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29				29
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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	(51,186)		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$	St. Clair Estates	100.00%	\$ 400	\$ 400	1
2	V	20 Dues, Fees, Subscriptions		St. Clair Estates	100.00%	39	39	2
3	V	21 Clerical & General Office Exp		St. Clair Estates	100.00%	168	168	3
4	V	30 Depreciation		St. Clair Estates	100.00%	11,578	11,578	4
5	V	32 Interest Expense		St. Clair Estates	100.00%	18,029	18,029	5
6	V	34 Rent	162,979	St. Clair Estates	100.00%		(162,979)	6
7	V	43 Non-Allowable Expenses		St. Clair Estates	100.00%	2,007	2,007	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 162,979			\$ 32,221	\$ * (130,758)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	John C. Schaufler	20.70						1
2	Herschel Parrish Jr.	13.75						2
3	Verlan Heberer	6.90						3
4	Barbara Holland	6.90						4
5	Alice Langstraat	6.90						5
6	Carolyn Stumpf	6.90						6
7	Dale Towers Declaration of Trust	6.90						7
8	Nancy L. Leonard	3.45						8
9	Charles W. Borrenpohl	3.45						9
10	Lavonne Kaiser	3.45						10
11	Amy Menges	3.45						11
12	Kathy L. Lickenbrock	3.45						12
13	Dale J. Lickenbrock	3.45						13
14	Larry Rhutasel, Trustee	3.45						14
15	Marjorie Rhutasel, Trustee	3.45						15
16	Frank X. Heiligenstein	3.44						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Rhutasel	Consultant	Admin Consultant	3.45	None	2	5.00	Admin Cons.	\$ 6,400	L 19, C3	1
2	John Schaufler	Consultant	Admin Consultant	20.70	None	2	5.00	Admin Cons.	4,000	L 19, C3	2
3	Dale Towers	Vice President	Board Member	6.90	None	N/A	N/A	Director Fees	1,200	L 18, C3	3
4	John Schaufler	President	Board Member	20.70	None	N/A	N/A	Director Fees	3,600	L 18, C3	4
5	Larry Rhutasel	Sec/Treasurer	Board Member	3.45	None	N/A	N/A	Director Fees	4,400	L 18, C3	5
6	Frank Heiligenstein	Director	Board Member	3.44	None	N/A	N/A	Director Fees	1,200	L 18, C3	6
7	Carolyn Stumpf	Director	Board Member	6.90	None	N/A	N/A	Director Fees	1,200	L 18, C3	7
8	Zoe Rhutasel	Clerical Staff	Clerical	0.00	None	1.24	100.00	Wages	610	L 21, C3	8
9											9
10	Each owner was paid their proportionate share of interest earned on the \$290,000 shareholder loan totaling \$11,239 for the year. This interest expense has been										10
11	disallowed on the cost reort.										11
12											12
13								TOTAL	\$ 22,610		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	Citizens Bank		X	Renovation	\$1,061.50	12/29/16	\$ 250,000	\$	Paid Off	0.0500	\$ 8,872	1								
2	Citizens Bank		X	Renovation	\$5,791.12	10/20/16	163,000	89,507		0.0500	6,245	2								
3	Citizens Bank		X	Renovation	\$430.35	12/29/16	105,000		Paid Off	0.0500	2,912	3								
4												4								
5												5								
Working Capital																				
6	Shareholder Loan	X		Working Capital	Demand	1/1/94	290,000	290,000	Demand	0.0325	11,239	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 808,000	\$ 379,507			\$ 29,268	9								
B. Non-Facility Related*																				
10												10								
11									Offset Interest Income		(672)	11								
12									Disallow Related Party Interest Exp		(10,567)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (11,239)	14								
15	TOTALS (line 9+line14)						\$ 808,000	\$ 379,507			\$ 18,029	15								

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	50,000	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.)	2016	\$	53,246	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,246	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	54,000	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.		\$	57,246	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	41,870	8
	2013	44,502	9
	2014	46,660	10
	2015	49,562	11
	2016	53,246	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Freeburg Care Center COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0025098

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>
1. <u>14-29.0-400-040</u>	<u>Long Term Care Property</u>	\$ <u>53,207.04</u>	\$ <u>53,207.04</u>
2. <u>14-29.0-400-038</u>	<u>Long Term Care Property</u>	\$ <u>38.58</u>	\$ <u>38.58</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>53,245.62</u></u>	\$ <u><u>53,245.62</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Freeburg Care Center

0025098 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,405 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>150,000</u>	<u>1979</u>	<u>\$ 22,480</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	150,000		\$ 22,480	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98			1979	\$ 1,174,206	\$	30	\$	\$	\$ 1,174,206	4
5	10			1985	227,899		30			227,899	5
6				1985	3,116		30			3,116	6
7				1989	2,110		27			2,110	7
8	10			1998	411,348		39.5	10,415	10,415	213,456	8
	Improvement Type**										
9		Parking Lot/title Insurance		1981	7,109		30			7,109	9
10		Sidewalk		1983	908		20			908	10
11		Laundry Renovation		1983	3,303		25			3,303	11
12		Storage Building		1983	6,690		20			6,690	12
13		Window Replacement		1983	967		30			967	13
14		Kitchen Renovations		1983	734		25			734	14
15		Ventilation System/ Insulation		1984	1,132		10			1,132	15
16		Concrete Paving		1985	4,124		20			4,124	16
17		Parking Lot		1986	2,518		10			2,518	17
18		Driveway		1987	3,990		15			3,990	18
19		Driveway		1989	1,465		15			1,465	19
20		Entry Sign		1990	2,890		15			2,890	20
21		Parking Lot		1990	11,951		20			11,951	21
22		Sewer		1990	17,548		25			17,548	22
23		Lights		1990	1,140		10			1,140	23
24		Heat Pumps/compressor		1990	2,527		8			2,527	24
25		Sewer Repairs/driveway Repairs/plumbing		1991	4,471		15			4,471	25
26		Rooftop Air Conditioner		1991	4,600		8			4,600	26
27		Front Office Remodeling/ Driveway Repairs		1992	10,838		15			10,838	27
28		Carpet		1992	14,036		5			14,036	28
29		Parking Lot And Driveway		1993	14,900		15			14,900	29
30		Fence/parking Lot & Driveway		1994	6,672		15			6,672	30
31		Ceiling Tile		1994	1,310		5			1,310	31
32		Landscaping		1996	1,499		10			1,499	32
33		Water Heater		1996	3,426		15			3,426	33
34		5 Ton Condensing Unit		1996	1,195		10			1,195	34
35		Water Line & Gas Line For Addition		1997	633		10			633	35
36		Air Compressor For Fire System		1997	1,244		10			1,244	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Ceramic Tile & Labor For Showers	1997	\$ 5,795	\$	10	\$	\$	\$ 5,795	37
38	Rock & Road Grading	1997	502		15			502	38
39	Remove Driveway & Reconcrete	1997	4,274		5			4,274	39
40	Labor & Material To Build Wall In Laundry Room	1997	503		15			503	40
41	Telephone System	1997	4,640		10			4,640	41
42	8 Ge Heat/cool Units	1997	7,624		10			7,624	42
43	Cabinets, Countertops & Labor For New Nurses Station And	1998	6,073		15			6,073	43
44	Gutting Old								44
45	Expanded Care Plan Office Adding Countertop & Windows	1998	6,952		15			6,952	45
46	Fire Alarm	1998	4,431		15			4,431	46
47	5 Ton Heating A/c Unit Roof Top	1998	2,918		15			2,918	47
48	Phone Jacks Installed	1998	777		15			777	48
49	4 Ge Heat/coot Units	1998	3,884		10			3,884	49
50	Replaced Ceiling Tile&Constructed New Storage Cabinets In	1999	4,951		10			4,951	50
51	Activity Room								51
52	Roof Top Fan	1999	866		15			866	52
53	Work On Rooftop A/c Unit	1999	3,170		14			3,170	53
54	New Roof On Wings A, B & C	1999	16,397		10			16,397	54
55	Wallpaper In Dining Room	2000	1,255		5			1,255	55
56	Gutted Bathroom, Installed Window & Worktop To Convert	2000	2,374		10			2,374	56
57	to DON Office								57
58	Finish Don Office-Mudd, Sand, And Paint Room, set cabinets	2001	2,194		10			2,194	58
59	&Build Shelves. Put Carpet &Cove Base Down& Handrail Up								59
60	Remove & Repair Concrete Entrance Sidewalk	2001	1,750		15			1,750	60
61	Remove Old Shower On D-hall & Put In New Shower Walls	2001	2,097		10			2,097	61
62	And Mudd, Sand, And Paint To Seal Plaster Around Shower								62
63	Tear Out Wall Between Secretary And Bookkeeper Office	2003	6,638		10			6,638	63
64	Build Countertops And Workspace, New Carpet, Paint, Etc								64
65	Build Up Roof Section	2004	8,072		10			8,072	65
66	New Roof On Flat Part Of Building	2005	66,376		10			66,376	66
67	firewall laundry room, fire ducts & ceiling tiles-oxygen room	2005	7,588		10			7,588	67
68	Replace Smoke Detectors	2005	4,457		10			4,457	68
69	5 Ton Air Conditioner	2006	4,621		10			4,621	69
70	TOTAL (lines 4 thru 69)		\$ 2,133,678	\$		\$ 10,415	\$ 10,415	\$ 1,935,786	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,133,678	\$		\$ 10,415	\$ 10,415	\$ 1,935,786	1
2	Sidewalks, Lighting, & Landscaping	2006	16,064		15	1,071	1,071	12,316	2
3	Parking Lot	2006	6,748		15	450	450	5,175	3
4	Replace Parts Of Backflow Preventor	2007	5,801	287	10	291	4	5,801	4
5	Landscape Front Of Building	2007	10,345	517	10	513	(4)	10,345	5
6	Remove & Replace Old Sidewalks & Parking Lot	2007	29,079	1,939	15	1,939		20,359	6
7	Canopy Addition	2008	15,191	1,013	15	1,013		9,623	7
8	Dawn To Dusk Lighting	2008	1,543	154	10	154		1,464	8
9	D2 Doors Replaced	2009	3,321	221	15	221		1,879	9
10	5 Ton Rooftop Unit	2009	7,217	722	10	722		6,137	10
11	Rooftop Repair West Wing	2009	7,375	524	7		(524)	7,375	11
12	Remove And Redesign Nurses Station, New Cabinets, Floor	2010	17,500	1,750	10	1,750		13,125	12
13	And Countertops								13
14	Repair Kitchen Wall For Damage From Leaking, New Frp	2010	3,000	600	5		(600)	3,000	14
15	Covering And Covebase And Structurally Fixed								15
16	2 Exit Doors And Hardware	2010	2,408	161	15	161		1,207	16
17	Repair To Sprinkler System Due To Leaking And Rusting	2010	3,983	398	10	398		2,985	17
18	Replaced Piping And Got System Operational								18
19	52 Doors And Hinges	2010	23,732	1,582	15	1,582		11,865	19
20	All Other Doors And Hinges	2011	37,880	2,525	15	2,525		16,413	20
21	Flooring Vct Tile Halls A,b,&c	2011	14,004	1,400	10	1,400		9,100	21
22	2 Countertops In Kitchen	2011	2,807	281	10	281		1,826	22
23	New Part Of Parking Lot	2011	12,000	800	15	800		5,200	23
24	New D Hall Roof	2011	6,995	700	10	700		4,550	24
25	Laundry Combustion Air And Ceiling Drywall	2012	13,234	1,323	10	1,323		7,277	25
26	C-hall Roof Replaced	2012	13,000	1,300	10	1,300		7,150	26
27	A-hall Roof Replaced	2012	13,225	1,323	10	1,323		7,276	27
28	Replaced Front Entry Glass	2012	2,055	137	15	137		754	28
29	Test On 9 Sprinkler Heads & Replaced	2012	4,360	291	15	291		1,600	29
30	Install Hot Water Heater	2013	8,866	887	10	887		3,991	30
31	Replace Dry Sprinkler Pendants	2013	11,500	1,150	10	1,150		5,175	31
32	Replace Windows In Rooms 1-7	2013	3,137	314	10	314		1,413	32
33	Install Air Handler In Janitors Closet	2013	4,540	227	20	227		1,022	33
34	TOTAL (lines 1 thru 33)		\$ 2,434,588	\$ 22,526		\$ 33,338	\$ 10,812	\$ 2,121,189	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,434,588	\$ 22,526		\$ 33,338	\$ 10,812	\$ 2,121,189	1
2	Storage Building	2014	2,540	254	20	127	(127)	445	2
3	Carpet in Admin Offices	2014	2,742	548	5	548		1,918	3
4	B Hall Room Replaced	2014	3,575	358	10	358		1,253	4
5	Replaced Ceiling Tile and Lights in Lobby Area	2014	5,562	695	8	695		2,433	5
6	Replaced Metal siding on shed	2014	8,850	885	10	885		3,098	6
7	Replaced Roof on Shed	2014	2,637	264	10	264		924	7
8	AC Condensing Unit on D Wing	2014	2,731	273	15	182	(91)	637	8
9	Replace D Hall Flooring Tile	2015	5,327	533	10	533		1,332	9
10	Replaced B Hall Bath Flooring and Fixtures	2015	5,872	150	39	294	144	735	10
11	Landscaping	2015	9,740	649	15	974	325	2,435	11
12	Install Roam Alert System-Main Entrance	2015	3,412	341	10	341		853	12
13	Installed Electricity to Storage Room (see line 3 above)	2015	1,640	164	10	82	(82)	205	13
14	Repair to Sprinkler System	2015	5,967	597	10	597		1,492	14
15	Prepping and painting walls, installed blinds in dining and								15
16	admin areas, installed vinyl wall coverings throughout the								16
17	bldg., updated nurses stations, built cabinet for dining area								17
18	and sound systems	2015	140,491	3,603	39	7,024	3,421	10,536	18
19	Replaced Lighting Throughout Halls/Dining Areas/Nurses Station	2016	19,816	509	10	1,982	1,473	2,973	19
20	Sprinkler system improvements including new compressor	2016	6,210	159	15	414	255	621	20
21	Installed 62 blinds in resident rooms	2016	6,264	626	10	626		939	21
22	Prep and paint walls and ceilings in nurses station and halls,								22
23	eating area, paint door frames and fire doors	2016	5,275	135	5	1,055	920	1,583	23
24	Installed 43 Privacy Curtains	2016	4,798	480	5	960	480	1,440	24
25	Signage in Building	2016	2,839	284	5	568	284	852	25
26	Removed and replaced bushes, rock, mulch	2016	3,733	249	10	373	124	560	26
27	Installed New Windows in Resident Rooms	2016	17,997	461	30	600	139	900	27
28	Replaced compressor on roof top A/C unit	2016	2,725	70	15	182	112	273	28
29	Awnings over serving windows in dining room	2016	6,722	672	5	1,344	672	2,016	29
30	Remove and replace vinyl tile in rooms D10-11	2016	2,730	273	10	273		410	30
31	Shower Room Remodel-Removed and replaced drywall, floor								31
32	and shower tile, painted walls, repaired plumbing, sink,								32
33	fixtures, grab bars, shelving, toilet and cabinet	2016	23,972	615	20	600	(15)	1,200	33
34	TOTAL (lines 1 thru 33)		\$ 2,738,755	\$ 36,373		\$ 55,219	\$ 18,846	\$ 2,163,252	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,738,755	\$ 36,373		\$ 55,219	\$ 18,846	\$ 2,163,252	1
2	Installed Wireless Access Point System	2016	4,100	820	5	820		1,230	2
3	Entrance Sign by Road	2016	5,800	580	10	580		870	3
4	Tile-Care Plan Office/Therapy Office	2017	3,129	156	10	156		156	4
5	Parking Lot Expansion	2017	40,201	1,005	20	1,005		1,005	5
6	Roof Repairs	2017	12,394	310	20	310		310	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,804,379	\$ 39,244		\$ 58,090	\$ 18,846	\$ 2,166,823	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 349,129	\$ 14,994	\$ 14,994	\$	5-15 Yrs	\$ 154,513	71
72	Current Year Purchases	6,578	329	329		10 Years	329	72
73	Fully Depreciated Assets	333,412					333,412	73
74	From St Clair Estates	187,737					187,737	74
75	TOTALS	\$ 876,856	\$ 15,323	\$ 15,323	\$		\$ 675,991	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,703,715	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,567	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,413	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,846	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,842,814	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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 N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 16,428 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Mattress	4,215
Washing Machine	6,085
Dish Machine	1,120
Water Cooler	166
Medical Equipment	3,850
Miscellaneous	992
Total - Line 16	16,428

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,063	\$ 323,872	\$	6,063	\$ 323,872	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,435	165,982		2,435	165,982	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		6,231	325,787	1,069	6,231	326,856	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 prescripts				87,247		87,247	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Oxygen</u>	39(3)					8,447		8,447	13
14	TOTAL			\$	14,729	\$ 815,641	\$ 96,763	14,729	\$ 912,404	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 90,628	\$ 111,120	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 105,000)	2,271,077	2,271,077	3
4	Supply Inventory (priced at Cost)	3,055	3,055	4
5	Short-Term Investments			5
6	Prepaid Insurance	96,661	96,661	6
7	Other Prepaid Expenses	1,158	2,148	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	20,650	20,650	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,483,229	\$ 2,504,711	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		22,480	13
14	Buildings, at Historical Cost	62,301	1,818,679	14
15	Leasehold Improvements, at Historical Cost	772,249	985,700	15
16	Equipment, at Historical Cost	709,410	876,856	16
17	Accumulated Depreciation (book methods)	(975,341)	(2,842,814)	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)	\$ 568,619	\$ 860,901	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,051,848	\$ 3,365,612	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 489,036	\$ 489,036	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,662	99,662	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,011	10,011	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,000	54,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	141,821	141,821	36
37	Due to Related Party	290,832		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,085,362	\$ 794,530	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	343,246	379,507	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 343,246	\$ 379,507	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,428,608	\$ 1,174,037	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,623,240	\$ 2,191,575	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,051,848	\$ 3,365,612	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/2017

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
INSURANCE	96,618	96,618
401K LIABILITY	11,102	11,102
ACCR LIC BED TAX	34,101	34,101
Total - Line 36	141,821	141,821

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,461,875	1
2	Restatements (describe):		2
3	Prior Period Adjustment-Utilities	(14,499)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,447,376	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	175,864	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)	\$ 175,864	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,623,240	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,599,334	1
2	Discounts and Allowances for all Levels	(63,449)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,535,885	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	502,294	6
7	Oxygen	(854)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 501,440	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	55	13
14	Non-Patient Meals	3,469	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,281	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	445	19
20	Radiology and X-Ray	(1,081)	20
21	Other Medical Services	11,598	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,767	23
D. Non-Operating Revenue			
24	Contributions	1,505	24
25	Interest and Other Investment Income***	672	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,177	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	2,334	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,334	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,059,603	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,204,346	31
32	Health Care	2,649,182	32
33	General Administration	910,613	33
B. Capital Expense			
34	Ownership	302,459	34
C. Ancillary Expense			
35	Special Cost Centers	1,559,570	35
36	Provider Participation Fee	257,569	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,883,739	40
41	Income before Income Taxes (line 30 minus line 40)**	175,864	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 175,864	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,373,912	44
45	Private Pay - Net Inpatient Revenue	3,031,921	45
46	Medicare - Net Inpatient Revenue	2,130,052	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,535,885	49

Note 1 - This entity is a cash basis tax payer

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A-Note 1 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/2017

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
OTHER INCOME	423
ACT & CONT INCOME	1,081
VENDING INCOME	830
Total - Line 28	<u>2,334</u>

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,936	2,080	\$ 70,451	\$ 33.87	1
2	Assistant Director of Nursing	2,696	3,012	79,358	26.35	2
3	Registered Nurses	9,825	10,465	279,046	26.66	3
4	Licensed Practical Nurses	27,906	30,346	625,461	20.61	4
5	CNAs & Orderlies	67,686	70,888	996,818	14.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,544	5,848	77,621	13.27	10
11	Social Service Workers	1,895	2,120	45,769	21.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,966	24,586	282,311	11.48	15
16	Dishwashers					16
17	Maintenance Workers	5,929	6,409	98,201	15.32	17
18	Housekeepers	18,247	20,089	202,644	10.09	18
19	Laundry	6,618	7,257	73,240	10.09	19
20	Administrator	1,976	2,080	117,540	56.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,431	6,807	133,544	19.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Ward Clerk</u>	3,375	3,596	43,441	12.08	32
33	Other(specify) <u>Marketing</u>	1,531	1,703	48,852	28.69	33
34	TOTAL (lines 1 - 33)	184,561	197,286	\$ 3,174,297 *	\$ 16.09	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	165	\$ 8,242	L1,C3	35
36	Medical Director	Monthly	14,400	L9,C3	36
37	Medical Records Consultant	Quarterly	880	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,993	L11,C3	44
45	Social Service Consultant	30	1,992	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	225	\$ 27,507		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 384	L10, C3	50
51	Licensed Practical Nurses	863	30,324	L10, C3	51
52	Certified Nurse Assistants/Aides	11,181	258,257	L10, C3	52
53	TOTAL (lines 50 - 52)	12,052	\$ 288,965		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>Amy Bonta</u>	<u>Administrator</u>	<u>0</u>	\$ <u>117,540</u>	<u>Workers' Compensation Insurance</u>	\$ <u>54,221</u>	<u>IDPH License Fee</u>	\$ <u>1,992</u>		
				<u>Unemployment Compensation Insurance</u>	<u>35,473</u>	<u>Advertising: Employee Recruitment</u>			
				<u>FICA Taxes</u>	<u>241,173</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>15,890</u>	(Indicate # of checks performed <u>18</u>)	<u>522</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>160</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>1,456</u>		
				<u>Vaccines</u>	<u>354</u>	<u>Miscellaneous Subscriptions</u>	<u>1,664</u>		
				<u>Drug Testing</u>	<u>1,686</u>	<u>All Scripts</u>	<u>1,788</u>		
				<u>401(k) Expense</u>	<u>9,897</u>				
				<u>Other Employee Benefits</u>	<u>10,449</u>				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									
			\$ <u>117,540</u>						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description		Line #	Amount	Description	Amount
<u>N/A</u>			\$	<u>N/A</u>				<u>Out-of-State Travel</u>	\$
								<u>In-State Travel</u>	
								<u>Seminar Expense</u>	<u>205</u>
								<u>Entertainment Expense</u>	()
								TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$ <u>369,143</u>	\$ <u>8,926</u>	
(Attach a copy of any management service agreement)									
C. Professional Services				G. Schedule of Travel and Seminar**			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description		Line #	Amount	Description	Amount
<u>Richard Breslin</u>	<u>Accounting</u>	\$ <u>2,105</u>						<u>Out-of-State Travel</u>	\$
<u>John Schaulfer</u>	<u>Administrative Consultant</u>	<u>6,400</u>						<u>In-State Travel</u>	
<u>Larry Rhutasel</u>	<u>Administrative Consultant</u>	<u>4,000</u>						<u>Seminar Expense</u>	<u>205</u>
<u>Wappooh Consulting</u>	<u>Administrative Services</u>	<u>38,267</u>						<u>Entertainment Expense</u>	()
<u>Templin Healthcare Accounting Svc</u>	<u>Accounting</u>	<u>35,069</u>						TOTAL (agree to Sch. V, line 24, col. 8)	
<u>Benetech</u>	<u>401k Administration</u>	<u>2,190</u>						\$ <u>205</u>	
<u>Point Click Care</u>	<u>Data Processing</u>	<u>12,531</u>							
<u>Freestone Computing</u>	<u>Computer Services</u>	<u>212</u>							
<u>PC Cruiser</u>	<u>Computer Services</u>	<u>742</u>							
<u>Ability Network</u>	<u>Data Processing</u>	<u>2,882</u>							
<u>Vision Websoft</u>	<u>Website</u>	<u>60</u>							
<u>ADP</u>	<u>Payroll Processing</u>	<u>2,968</u>							
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>107,426</u>						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Freeburg Care Center

0025098

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 257,569
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. \$ 3,469
- (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? 100% of L14
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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? _____
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT