		FOR BHF USE			

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2020)

I. IDPH License ID Number: 0025098

Facility Name: Freeburg Care Center

Address: 746 Urbanna Drive (Number) Freeburg (City) 62243 (Zip Code)

County: St Clair

Telephone Number: (618) 539-5856 Fax # (618) 539-3412

HFS ID Number:

Date of Initial License for Current Owners: 3/14/79

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/20 to 12/31/20 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)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	Larry Templin Partner
	(Firm Name & Address)	Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326
	(Telephone)	(630) 361-2868 Fax # ( )

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: 630-361-2868
Email Address:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	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	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,901	3,901	8
9	SNF/PED					9
10	ICF	13,475	16,687		30,162	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,475	16,687	3,901	34,063	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.87%

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 [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 3,901

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

* 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: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	382,696	41,803	13,497	437,996		437,996		437,996			1
2	Food Purchase		335,318		335,318		335,318	(1,709)	333,609			2
3	Housekeeping	234,072	38,958		273,030		273,030		273,030			3
4	Laundry	98,597	54,013		152,610		152,610		152,610			4
5	Heat and Other Utilities			146,765	146,765		146,765		146,765			5
6	Maintenance	78,916	48,766	72,439	200,121		200,121		200,121			6
7	Other (specify):* Waste Disposal			19,834	19,834		19,834		19,834			7
8	TOTAL General Services	794,281	518,858	252,535	1,565,674		1,565,674	(1,709)	1,563,965			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,311,291	105,242	130,013	2,546,546		2,546,546		2,546,546			10
10a	Therapy											10a
11	Activities	155,210	15,512	4,933	175,655		175,655		175,655			11
12	Social Services	50,441			50,441		50,441		50,441			12
13	CNA Training											13
14	Program Transportation			1,203	1,203		1,203		1,203			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,516,942	120,754	154,149	2,791,845		2,791,845		2,791,845			16
	C. General Administration											
17	Administrative	128,499			128,499		128,499		128,499			17
18	Directors Fees			10,000	10,000		10,000		10,000			18
19	Professional Services			100,931	100,931		100,931	(410)	100,521			19
20	Dues, Fees, Subscriptions & Promotions			12,008	12,008		12,008	(25)	11,983			20
21	Clerical & General Office Expenses	204,481	31,743	7,898	244,122		244,122	(2,856)	241,266			21
22	Employee Benefits & Payroll Taxes			374,458	374,458		374,458		374,458			22
23	Inservice Training & Education			247	247		247		247			23
24	Travel and Seminar			464	464		464		464			24
25	Other Admin. Staff Transportation			1,129	1,129		1,129		1,129			25
26	Insurance-Prop.Liab.Malpractice			109,220	109,220		109,220		109,220			26
27	Other (specify):*											27
28	TOTAL General Administration	332,980	31,743	616,355	981,078		981,078	(3,291)	977,787			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,644,203	671,355	1,023,039	5,338,597		5,338,597	(5,000)	5,333,597			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.

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			67,521	67,521		67,521	19,444	86,965			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,056	11,056		11,056	(11,056)				32
33	Real Estate Taxes			59,298	59,298		59,298		59,298			33
34	Rent-Facility & Grounds			174,000	174,000		174,000	(174,000)				34
35	Rent-Equipment & Vehicles			33,146	33,146		33,146		33,146			35
36	Other (specify):*											36
37	TOTAL Ownership			345,021	345,021		345,021	(165,612)	179,409			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,949	395,811	479,760		479,760		479,760			39
40	Barber and Beauty Shops			11,024	11,024		11,024		11,024			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,168	248,168		248,168		248,168			42
43	Other (specify):* See Att Sch 4A	58,039		134,833	192,872		192,872	(168,916)	23,956			43
44	TOTAL Special Cost Centers	58,039	83,949	789,836	931,824		931,824	(168,916)	762,908			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,702,242	755,304	2,157,896	6,615,442		6,615,442	(339,528)	6,275,914			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 1/1/20
Period End 12/31/20

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			18,065	18,065		18,065		18,065			
	Radiology Expenses			5,891	5,891		5,891		5,891			
	Non-Allowable Expenses	58,039		110,877	168,916		168,916	(168,916)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	58,039	0	134,833	192,872	0	192,872	(168,916)	23,956			

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,709)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,298)	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	7,516	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,572)	43		13
14	Non-Care Related Interest	(11,056)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(25)	20		17
18	Fines and Penalties	(245)	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	(91,382)	43		24
25	Fund Raising, Advertising and Promotional	(15,380)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,651)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(62,283)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (180,085)		$	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)	(159,443)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (159,443)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (339,528)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Freeburg Care Center

ID# 0025098

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income	$ (2,889)	21	1
2	Disallow Marketing Wages	(58,039)	43	2
3	Disallow Collection Fees	(1,355)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(62,283)		49

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Page 6 - Supplemental		None		St Clair Estates	Freeburg	Lessor

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	19	Professional Services	$	St. Clair Estates	100.00%	$ 945	$ 945	1
2	V	21	Clerical & General Office Expenses		St. Clair Estates	100.00%	33	33	2
3	V	30	Depreciation		St. Clair Estates	100.00%	11,928	11,928	3
4	V	34	Rent	174,000	St. Clair Estates	100.00%		(174,000)	4
5	V	43	Non-Allowable Expenses		St. Clair Estates	100.00%	1,651	1,651	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			$ 174,000			$ 14,557	$ * (159,443)	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: 1/1/20 Ending: 12/31/20

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	None		None			1
2	Herschel Parrish Jr.	13.75						2
3	Estate of Verlan Heberer	6.90						3
4	Barbara Holland	6.90						4
5	Alice Langstraat	6.90						5
6	Carolyn Stumpf	6.90						6
7	Brad 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: 1/1/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Larry Rhutasel	Consultant	Admin Consultant	3.45	None	2	5.00	Admin Cons.	$ 9,600	L 19, C3	1
2	John Schaufler	Consultant	Admin Consultant	20.70	None	2	5.00	Admin Cons.	6,000	L 19, C3	2
3	Herschel Parrish	Director	Board Member	13.75	None	N/A	N/A	Director Fees	2,000	L 18, C3	3
4	John Schaufler	President	Board Member	20.70	None	N/A	N/A	Director Fees	2,000	L 18, C3	4
5	Larry Rhutasel	Sec/Treasurer	Board Member	3.45	None	N/A	N/A	Director Fees	2,000	L 18, C3	5
6	Frank Heiligenstein	Director	Board Member	3.44	None	N/A	N/A	Director Fees	2,000	L 18, C3	6
7	Dale Lickenbrock	Director	Board Member	6.90	None	N/A	N/A	Director Fees	2,000	L 18, C3	7
8											8
9											9
10	Each owner was paid their proportionate share of interest earned on the $290,000 shareholder loan totaling $14,319 for the year. This interest expense has been										10
11	disallowed on the cost report.										11
12											12
13								TOTAL	$ 25,600		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: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6		N/A								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: 1/1/20 Ending: 12/31/20

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											$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loan	X		Working Capital	Demand	1/1/94	290,000		Demand	0.0475	11,056	6
7												7
8												8
9	TOTAL Facility Related						$ 290,000	$			$ 11,056	9
	B. Non-Facility Related*											
10												10
11												11
12								Disallow Related Party Interest Exp			(11,056)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,056)	14
15	TOTALS (line 9+line14)						$ 290,000	$			$	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.)

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.		$ 56,000	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.)	2019	$ 57,298	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,298	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 58,000	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.		$ 59,298	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	46,660	8
2016	49,562	9
2017	54,524	10
2018	56,348	11
2019	57,298	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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

2019 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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	14-29.0-400-040	Long Term Care Property	$ 57,256.48	$ 57,256.48
2.	14-29.0-400-038	Long Term Care Property	$ 41.64	$ 41.64
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,298.12	$ 57,298.12

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [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: 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	Nursing Home	150,000	1979	$ 22,480	1
2					2
3	TOTALS	150,000		$ 22,480	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98			1979	$ 1,174,206	$	30	$	$	$ 1,174,206	4
5	10			1985	227,899		30			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	10,416	10,416	244,703	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			4,771	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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ceramic Tile & Labor For Showers	1997	$ 5,795	$	10	$	$	$ 5,795	37
38	Rock & Road Grading	1997	502		15			502	38
39	Remove Driveway & Reconcrete	1997	4,274		5			4,274	39
40	Labor & Material To Build Wall In Laundry Room	1997	503		15			503	40
41	Telephone System	1997	4,640		10			4,640	41
42	8 Ge Heat/cool Units	1997	7,624		10			7,624	42
43	Cabinets, Countertops & Labor For New Nurses Station And	1998	6,073		15			6,073	43
44	Gutting Old								44
45	Expanded Care Plan Office Adding Countertop & Windows	1998	6,952		15			6,952	45
46	Fire Alarm	1998	4,431		15			4,431	46
47	5 Ton Heating A/c Unit Roof Top	1998	2,918		15			2,918	47
48	Phone Jacks Installed	1998	777		15			777	48
49	4 Ge Heat/coot Units	1998	3,884		10			3,884	49
50	Replaced Ceiling Tile&Constructed New Storage Cabinets In	1999	4,951		10			4,951	50
51	Activity Room								51
52	Roof Top Fan	1999	866		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	$		$ 10,416	$ 10,416	$ 1,967,680	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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,133,678	$		$ 10,416	$ 10,416	$ 1,967,680	1
2	Sidewalks, Lighting, & Landscaping	2006	16,064		15	1,068	1,068	15,523	2
3	Parking Lot	2006	6,748		15	444	444	6,513	3
4	Replace Parts Of Backflow Preventor	2007	5,801		10			5,801	4
5	Landscape Front Of Building	2007	10,345		10			10,345	5
6	Remove & Replace Old Sidewalks & Parking Lot	2007	29,079	1,939	15	1,939		26,176	6
7	Canopy Addition	2008	15,191	1,013	15	1,013		12,662	7
8	Dawn To Dusk Lighting	2008	1,543		10			1,543	8
9	D2 Doors Replaced	2009	3,321	221	15	221		2,542	9
10	5 Ton Rooftop Unit	2009	7,217	358	10		(358)	7,217	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	875	10	875		17,500	12
13	And Countertops								13
14	Repair Kitchen Wall For Damage From Leaking, New Frp	2010	3,000		5			3,000	14
15	Covering And Covebase And Structurally Fixed								15
16	2 Exit Doors And Hardware	2010	2,408	161	15	161		1,690	16
17	Repair To Sprinkler System Due To Leaking And Rusting	2010	3,983	202	10	202		3,983	17
18	Replaced Piping And Got System Operational								18
19	52 Doors And Hinges	2010	23,732	1,582	15	1,582		16,611	19
20	All Other Doors And Hinges	2011	37,880	2,525	15	2,525		23,988	20
21	Flooring Vct Tile Halls A,b,&c	2011	14,004	1,400	10	1,400		13,300	21
22	2 Countertops In Kitchen	2011	2,807	281	10	281		2,669	22
23	New Part Of Parking Lot	2011	12,000	800	15	800		7,600	23
24	New D Hall Roof	2011	6,995	700	10	700		6,650	24
25	Laundry Combustion Air And Ceiling Drywall	2012	13,234	1,323	10	1,323		11,246	25
26	C-hall Roof Replaced	2012	13,000	1,300	10	1,300		11,050	26
27	A-hall Roof Replaced	2012	13,225	1,323	10	1,323		11,245	27
28	Replaced Front Entry Glass	2012	2,055	137	15	137		1,165	28
29	Test On 9 Sprinkler Heads & Replaced	2012	4,360	291	15	291		2,473	29
30	Install Hot Water Heater	2013	8,866	887	10	887		6,652	30
31	Replace Dry Sprinkler Pendants	2013	11,500	1,150	10	1,150		8,625	31
32	Replace Windows In Rooms 1-7	2013	3,137	314	10	314		2,355	32
33	Install Air Handler In Janitors Closet	2013	4,540	227	20	227		1,703	33
34	TOTAL (lines 1 thru 33)		$ 2,434,588	$ 19,533		$ 30,579	$ 11,046	$ 2,216,882	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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,434,588	$ 19,533		$ 30,579	$ 11,046	$ 2,216,882	1
2	Storage Building	2014	2,540	254	10	127	(127)	826	2
3	Carpet in Admin Offices	2014	2,742	(273)	5		273	2,742	3
4	B Hall Room Replaced	2014	3,575	358	10	358		2,327	4
5	Replaced Ceiling Tile and Lights in Lobby Area	2014	5,562	695	8	695		4,518	5
6	Replaced Metal siding on shed	2014	8,850	885	10	885		5,753	6
7	Replaced Roof on Shed	2014	2,637	264	10	264		1,716	7
8	AC Condensing Unit on D Wing	2014	2,731	273	15	273		1,274	8
9	Replace D Hall Flooring Tile	2015	5,327	533	10	533		2,931	9
10	Replaced B Hall Bath Flooring and Fixtures	2015	5,872	150	39	294	144	1,617	10
11	Landscaping	2015	9,740	649	15	974	325	5,357	11
12	Install Roam Alert System-Main Entrance	2015	3,412	341	10	341		1,876	12
13	Installed Electricity to Storage Room (see line 3 above)	2015	1,640	164	10	82	(82)	451	13
14	Repair to Sprinkler System	2015	5,967	597	10	597		3,283	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	31,608	18
19	Replaced Lighting Throughout Halls/Dining Areas/Nurses Station	2016	19,816	509	10	1,982	1,473	8,919	19
20	Sprinkler system improvements including new compressor	2016	6,210	159	15	414	255	1,863	20
21	Installed 62 blinds in resident rooms	2016	6,264	626	10	626		2,817	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	4,748	23
24	Installed 43 Privacy Curtains	2016	4,798	480	5	960	480	4,320	24
25	Signage in Building	2016	2,839	284	5	568	284	2,556	25
26	Removed and replaced bushes, rock, mulch	2016	3,733	249	10	373	124	1,679	26
27	Installed New Windows in Resident Rooms	2016	17,997	461	30	600	139	2,700	27
28	Replaced compressor on roof top A/C unit	2016	2,725	70	15	182	112	819	28
29	Awnings over serving windows in dining room	2016	6,722	672	5	1,344	672	6,048	29
30	Remove and replace vinyl tile in rooms D10-11	2016	2,730	273	10	273		1,229	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)	3,000	33
34	TOTAL (lines 1 thru 33)		$ 2,738,755	$ 32,559		$ 52,003	$ 19,444	$ 2,323,859	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: 1/1/20 Ending: 12/31/20

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	$ 32,559		$ 52,003	$ 19,444	$ 2,323,859	1
2	Installed Wireless Access Point System	2016	4,100	820	5	820		3,690	2
3	Entrance Sign by Road	2016	5,800	580	10	580		2,610	3
4	Tile-Care Plan Office/Therapy Office	2017	3,129	313	10	313		1,095	4
5	Parking Lot Expansion	2017	40,201	2,010	20	2,010		7,035	5
6	Roof Repairs	2017	12,394	620	20	620		2,170	6
7	Flooring-Kitchen	2018	10,037	1,003	10	1,003		2,508	7
8	Rooftop A/C Unit	2018	11,487	1,149	10	1,149		2,872	8
9	Install 3 Tankless Water Heaters	2019	22,460	1,497	15	1,497		2,245	9
10	Parking Lot / Sidewalk Repairs	2019	20,992	1,400	15	1,400		2,100	10
11	Repair Parking Lot Drainage	2020	23,085	770	15	770		770	11
12	Bury Pipe-Rear Building	2020	2,750	91	15	91		91	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,895,190	$ 42,812		$ 62,256	$ 19,444	$ 2,351,045	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: 1/1/20 Ending: 12/31/20

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	$ 227,291	$ 17,474	$ 17,474	$	5-15 Yrs	$ 54,126	71
72	Current Year Purchases	5,657	283	283		10 Yrs	283	72
73	Fully Depreciated Assets	482,820					482,820	73
74	From St Clair Estates	187,737					187,737	74
75	TOTALS	$ 903,505	$ 17,757	$ 17,757	$		$ 724,966	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	Resident	2019 Ford E-350 Diamond Coach	2020	$ 69,518	$ 6,952	$ 6,952	$	5	$ 6,952	76
77										77
78										78
79										79
80	TOTALS			$ 69,518	$ 6,952	$ 6,952	$		$ 6,952	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)	$ 3,890,693	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,521	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,965	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,444	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,082,963	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

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: $ 33,146 Description: See Attached 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	N/A				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: 12/31/20

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Therapy Equipment	15,031
Laundry Equipment	8,855
Dish Machine	1,820
Office Equipment	575
Medical Equipment	4,213
Miscellaneous	2,652
Total - Line 16	**33,146**

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1	2	3	4	5	6	7	8	
		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	$	6,240	$ 166,536	$	6,240	$ 166,536	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,744	46,582		1,744	46,582	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		6,113	182,693	3,670	6,113	186,363	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				69,609		69,609	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Solutions	39(2)					384		384	12
13	Other (specify): Oxygen	39(2)					10,286		10,286	13
14	TOTAL			$	14,097	$ 395,811	$ 83,949	14,097	$ 479,760	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

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 1,083,113	$ 1,113,992	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	767,929	767,929	3
4	Supply Inventory (priced at Cost)	3,055	3,055	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,478	41,478	6
7	Other Prepaid Expenses	3,417	4,407	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,898,992	$ 1,930,861	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		1,818,679	14
15	Leasehold Improvements, at Historical Cost	925,362	1,076,511	15
16	Equipment, at Historical Cost	805,576	973,023	16
17	Accumulated Depreciation (book methods)	(1,154,857)	(3,082,963)	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)**	$ 576,081	$ 807,730	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,475,073	$ 2,738,591	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 172,743	$ 172,743	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,922	160,922	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,595	7,595	31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,000	58,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	906,585	906,585	36
37	Due to Related Party	178,620		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,484,465	$ 1,305,845	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,484,465	$ 1,305,845	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 990,608	$ 1,432,746	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,475,073	$ 2,738,591	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Freeburg Care Center
IDPH License ID Number: 0025098
Fiscal Year End: 12/31/20

Schedule 17A

XV. Balance Sheet

Line 37 Other

		Operating	After Consolidation
INSURANCE		27,017	27,017
401K LIABILITY		5,621	5,621
DEFERRED REVENUE		858,948	858,948
ACCR LIC BED TAX		14,999	14,999
	TOTAL	906,585	906,585

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 247,212	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 247,212	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	743,396	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)**	$ 743,396	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)**	$ 990,608	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 5,050,101	1
2	Discounts and Allowances for all Levels	1,375,153	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,425,254	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	191,699	6
7	Oxygen	445	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 192,144	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	705,175	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,348	13
14	Non-Patient Meals	1,709	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,364	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	654	19
20	Radiology and X-Ray	710	20
21	Other Medical Services	5,646	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 734,606	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,945	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,945	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	2,889	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,889	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,358,838	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,565,674	31
32	Health Care	2,791,845	32
33	General Administration	981,078	33
	B. Capital Expense		
34	Ownership	345,021	34
	C. Ancillary Expense		
35	Special Cost Centers	683,656	35
36	Provider Participation Fee	248,168	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,615,442	40
41	**Income before Income Taxes (line 30 minus line 40)****	743,396	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 743,396	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,685,772	44
45	Private Pay - Net Inpatient Revenue	2,727,053	45
46	Medicare - Net Inpatient Revenue	1,960,630	46
47	Other-(specify) Insurance	51,799	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,425,254	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete 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 & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	1,906	2,080	$ 85,139	$ 40.93	1
2	Assistant Director of Nursing	2,416	2,662	82,551	31.01	2
3	Registered Nurses	5,813	6,246	213,269	34.14	3
4	Licensed Practical Nurses	28,263	30,239	778,720	25.75	4
5	CNAs & Orderlies	62,660	66,599	1,077,957	16.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,945	12,722	155,210	12.20	10
11	Social Service Workers	1,431	1,610	50,441	31.33	11
12	Dietician					12
13	Food Service Supervisor	1,239	1,279	30,360	23.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,789	29,269	352,336	12.04	15
16	Dishwashers					16
17	Maintenance Workers	4,241	4,704	78,916	16.78	17
18	Housekeepers	16,268	17,872	234,072	13.10	18
19	Laundry	7,856	8,435	98,597	11.69	19
20	Administrator	1,926	2,080	128,499	61.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,318	9,083	204,481	22.51	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 Ca Ward Clerk	4,373	4,832	73,655	15.24	32
33	Other(specify) Marketing	1,550	1,729	58,039	33.57	33
34	TOTAL (lines 1 - 33)	187,994	201,441	$ 3,702,242 *	$ 18.38	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	Monthly	$ 13,497	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	Quarterly	1,080	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,384	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	Monthly	603	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 36,564		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	65	$ 3,384	L10, C3	50
51	Licensed Practical Nurses	54	2,312	L10, C3	51
52	Certified Nurse Assistants/Aides	4,532	117,838	L10, C3	52
53	TOTAL (lines 50 - 52)	4,651	$ 123,534		53

Facility Name & ID Number Freeburg Care Center # 0025098 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Amy Bonta	Administrator	0	$	128,499
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	128,499

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
Richard Breslin	Accounting	$	1,335
John Schaulfer	Administrative Consultant		6,000
Larry Rhutasel	Administrative Consultant		9,600
Templin Healthcare Accounting Svc	Accounting		19,407
Mediprocity	Computer Services		1,800
Point Click Care	Data Processing		13,818
Tekcollect	Collections		1,355
SNFQAPI, LLC	Compliance Consulting		4,620
Ability Network	Data Processing		3,351
ADP	Payroll Processing		31,473
See Attached Legal Schedule			8,172
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	100,931

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	53,197
Unemployment Compensation Insurance		31,209
FICA Taxes		256,241
Employee Health Insurance		6,891
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
401(k) Expense		4,999
Vaccinations		4,111
Other Employee Benefits		17,810
TOTAL (agree to Schedule V, line 22, col.8)	$	374,458

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

Description	Line #		Amount
N/A			
TOTAL		$	

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	1,725
Advertising: Employee Recruitment		1,243
Health Care Worker Background Check (Indicate # of checks performed)		1,820
Patient Background Checks		1,340
Miscellaneous Licenses & Fees		1,572
Miscellaneous Subscriptions		1,849
Allscripts		2,459
Less: Public Relations Expense		(25)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)	$	11,983

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		464
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	464

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Freeburg Care Center** **#** **0025098** **Report Period Beginning:** **1/1/20** **Ending:** **12/31/20**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **248,168**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,709**

(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% Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees