



Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

# 0047472 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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	22,783	3,666	4,043	30,492	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,783	3,666	4,043	30,492	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.24%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 10/01/05

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 10/01/05 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 98 and days of care provided 4,043

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cent # 0047472 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	169,581	19,119		188,700		188,700	3,030	191,730		1
2	Food Purchase		135,772		135,772		135,772	(3,594)	132,178		2
3	Housekeeping	137,736	17,160		154,896		154,896	98	154,994		3
4	Laundry	21,187	13,946		35,133		35,133		35,133		4
5	Heat and Other Utilities			79,982	79,982		79,982	402	80,384		5
6	Maintenance	24,916	44,244	25,982	95,142		95,142	(4,216)	90,926		6
7	Other (specify):* <b>Mgmt Alloc of Benefit</b>							1,887	1,887		7
8	<b>TOTAL General Services</b>	353,420	230,241	105,964	689,625		689,625	(2,393)	687,232		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,231,339	205,212	1,808	1,438,359		1,438,359	9,358	1,447,717		10
10a	Therapy		9,221	376,453	385,674		385,674	720	386,394		10a
11	Activities	42,935	3,183		46,118		46,118		46,118		11
12	Social Services	41,538	61		41,599		41,599		41,599		12
13	CNA Training										13
14	Program Transportation			734	734		734		734		14
15	Other (specify):* <b>Mgmt Alloc of Benefit</b>							2,945	2,945		15
16	<b>TOTAL Health Care and Programs</b>	1,315,812	217,677	384,995	1,918,484		1,918,484	13,023	1,931,507		16
	<b>C. General Administration</b>										
17	Administrative	58,670		84,000	142,670		142,670	(60,820)	81,850		17
18	Directors Fees										18
19	Professional Services			3,504	3,504		3,504	13,278	16,782		19
20	Dues, Fees, Subscriptions & Promotions			10,467	10,467		10,467	996	11,463		20
21	Clerical & General Office Expenses	36,881	6,045	3,291	46,217		46,217	43,212	89,429		21
22	Employee Benefits & Payroll Taxes			274,273	274,273		274,273	3,708	277,981		22
23	Inservice Training & Education			65	65		65	279	344		23
24	Travel and Seminar			25	25		25	804	829		24
25	Other Admin. Staff Transportation			4,949	4,949		4,949	3,604	8,553		25
26	Insurance-Prop.Liab.Malpractice			21,873	21,873		21,873	1,720	23,593		26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>							8,388	8,388		27
28	<b>TOTAL General Administration</b>	95,551	6,045	402,447	504,043		504,043	15,169	519,212		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,764,783	453,963	893,406	3,112,152		3,112,152	25,799	3,137,951		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

\*\*See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Fondulac Rehabilitation &amp; Health Care Center

#0047472

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			151,350	151,350		151,350	9,115	160,465			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			261,034	261,034		261,034	27,018	288,052			32
33	Real Estate Taxes			31,600	31,600		31,600	3,012	34,612			33
34	Rent-Facility & Grounds							1,371	1,371			34
35	Rent-Equipment & Vehicles			21,908	21,908		21,908	897	22,805			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			465,892	465,892		465,892	41,413	507,305			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,664		5,664		5,664		5,664			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* <b>Nonallowable Cost</b>			183,672	183,672		183,672	(183,672)				43
44	<b>TOTAL Special Cost Centers</b>		5,664	237,327	242,991		242,991	(183,672)	59,319			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,764,783	459,627	1,596,625	3,821,035		3,821,035	(116,460)	3,704,575			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,492)	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	(1,040)	30		9
10	Interest and Other Investment Income	(4,298)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(386)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(500)	43		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	(115,259)	43		24
25	Fund Raising, Advertising and Promotional	(16,221)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(68,065)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (209,261)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	92,801		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 92,801</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (116,460)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

<b>BHF USE ONLY</b>					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Fondulac Rehabilitation & Health Care Center

ID# 0047472

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-allowable marketing expense	\$ (6,174)	43	1
2	Labs-Part A	(14,396)	43	2
3	X-Rays-Part A	(5,049)	43	3
4	Marketing Supplies	(549)	43	4
5	Salaries Marketing/Other	(21,646)	43	5
6	Capitalize Repair & Maint.	(11,727)	6	6
7	Dues and Subscriptions	(498)	20	7
8	Non-allowable travel	(8,026)	24	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	<b>Total</b>	(68,065)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,169	0	861	0	0	0	0	0	0	0	3,030	1
2	Food Purchase	0	107	0	7	0	0	0	0	0	0	0	114	2
3	Housekeeping	0	96	0	2	0	0	0	0	0	0	0	98	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	402	0	0	0	0	0	0	0	0	0	402	5
6	Maintenance	(11,727)	5,514	0	1,997	0	0	0	0	0	0	0	(4,216)	6
7	Other (specify):*	0	869	0	1,018	0	0	0	0	0	0	0	1,887	7
8	<b>TOTAL General Services</b>	<b>(11,727)</b>	<b>9,157</b>	<b>0</b>	<b>3,885</b>	<b>0</b>	<b>1,315</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,839	0	1,519	0	0	0	0	0	0	0	9,358	10
10a	Therapy	0	720	0	0	0	0	0	0	0	0	0	720	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	2,424	0	521	0	0	0	0	0	0	0	2,945	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>10,983</b>	<b>0</b>	<b>2,040</b>	<b>0</b>	<b>13,023</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(62,630)	0	1,810	0	0	0	0	0	0	0	(60,820)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,359	0	3,919	0	0	0	0	0	0	0	13,278	19
20	Fees, Subscriptions & Promotions	(498)	917	0	577	0	0	0	0	0	0	0	996	20
21	Clerical & General Office Expenses	0	0	34,450	8,762	0	0	0	0	0	0	0	43,212	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	279	0	0	0	0	0	0	0	0	279	23
24	Travel and Seminar	(8,026)	0	0	804	0	0	0	0	0	0	0	(7,222)	24
25	Other Admin. Staff Transportation	0	0	10,560	1,070	0	0	0	0	0	0	0	11,630	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,642	78	0	0	0	0	0	0	0	1,720	26
27	Other (specify):*	0	0	6,088	2,300	0	0	0	0	0	0	0	8,388	27
28	<b>TOTAL General Administration</b>	<b>(8,524)</b>	<b>(52,354)</b>	<b>53,019</b>	<b>19,320</b>	<b>0</b>	<b>11,461</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(20,251)</b>	<b>(32,214)</b>	<b>53,019</b>	<b>25,245</b>	<b>0</b>	<b>25,799</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,040)	0	8,494	1,661	0	0	0	0	0	0	0	9,115	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,298)	0	4,718	26,598	0	0	0	0	0	0	0	27,018	32
33	Real Estate Taxes	0	0	996	2,016	0	0	0	0	0	0	0	3,012	33
34	Rent-Facility & Grounds	0	0	965	406	0	0	0	0	0	0	0	1,371	34
35	Rent-Equipment & Vehicles	0	0	506	391	0	0	0	0	0	0	0	897	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,338)</b>	<b>0</b>	<b>15,679</b>	<b>31,072</b>	<b>0</b>	<b>41,413</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(183,672)	0	0	0	0	0	0	0	0	0	0	(183,672)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(183,672)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(183,672)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(209,261)</b>	<b>(32,214)</b>	<b>68,698</b>	<b>56,317</b>	<b>0</b>	<b>(116,460)</b>	<b>45</b>						

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

**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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,169	\$ 2,169	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	107	107	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	96	96	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	402	402	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,514	5,514	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	869	869	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,839	7,839	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	720	720	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,424	2,424	10
11	V	17 Administrative	84,000	Petersen Health Care, Inc.	100.00%	21,370	(62,630)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	9,359	9,359	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	917	917	13
14	Total		\$ 84,000			\$ 51,786	\$ * (32,214)	14

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

VII. RELATED PARTIES (continued)

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 34,450	\$	34,450	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	279		279	16
17	V	25 Travel and Seminar		Petersen Health Care, Inc.	100.00%	8,341		8,341	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,219		2,219	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,642		1,642	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,088		6,088	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	8,494		8,494	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,718		4,718	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	996		996	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	965		965	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	506		506	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 68,698	\$ *	68,698	39

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## VII. RELATED PARTIES (continued)

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 861	\$	861	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	7		7	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	2		2	17
18	V								18
19	V								19
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,997		1,997	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,018		1,018	21
22	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,519		1,519	22
23	V								23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	521		521	24
25	V	17 Administrative		Petersen Health Care, Inc.	100.00%	1,810		1,810	25
26	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,919		3,919	26
27	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	577		577	27
28	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	8,762		8,762	28
29	V								29
30	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	804		804	30
31	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,070		1,070	31
32	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	78		78	32
33	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,300		2,300	33
34	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,661		1,661	34
35	V	32 Interest		Petersen Health Care, Inc.	100.00%	26,598		26,598	35
36	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	2,016		2,016	36
37	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	406		406	37
38	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	391		391	38
39	Total		\$			\$ 56,317	\$ *	56,317	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cen # 0047472 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.34	2.67	Salary	\$ 21,370	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,370		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' COMPILATION REPORT

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472

Report Period Beginning:

01/01/2006Ending: 2/31/2006

## 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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 West Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

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

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	<u>1</u>	<u>Dietary</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>\$ 81,179</u>	<u>\$ 80,967</u>	<u>30,492</u>	<u>\$ 2,169</u>	<u>1</u>
2	<u>2</u>	<u>Food</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>3,989</u>	<u>0</u>	<u>30,492</u>	<u>107</u>	<u>2</u>
3	<u>3</u>	<u>Housekeeping</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>3,589</u>	<u>0</u>	<u>30,492</u>	<u>96</u>	<u>3</u>
4	<u>4</u>									<u>4</u>
5	<u>5</u>	<u>Utilities</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>15,054</u>	<u>0</u>	<u>30,492</u>	<u>402</u>	<u>5</u>
6	<u>6</u>	<u>Maintenance</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>206,416</u>	<u>110,513</u>	<u>30,492</u>	<u>5,514</u>	<u>6</u>
7	<u>7</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>32,526</u>	<u>0</u>	<u>30,492</u>	<u>869</u>	<u>7</u>
8	<u>10</u>	<u>Nursing and Medical Records</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>293,462</u>	<u>289,197</u>	<u>30,492</u>	<u>7,839</u>	<u>8</u>
9	<u>10A</u>	<u>Therapy</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>26,945</u>	<u>0</u>	<u>30,492</u>	<u>720</u>	<u>9</u>
10	<u>15</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>90,724</u>	<u>0</u>	<u>30,492</u>	<u>2,424</u>	<u>10</u>
11	<u>17</u>	<u>Administrative</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>800,000</u>	<u>800,000</u>	<u>30,492</u>	<u>21,370</u>	<u>11</u>
12	<u>19</u>	<u>Professional Services</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>350,361</u>	<u>4,303</u>	<u>30,492</u>	<u>9,359</u>	<u>12</u>
13	<u>20</u>	<u>Due, Fees, Subs &amp; Promos</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>34,325</u>	<u>0</u>	<u>30,492</u>	<u>917</u>	<u>13</u>
14	<u>21</u>	<u>Clerical &amp; General Office</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>1,289,623</u>	<u>954,322</u>	<u>30,492</u>	<u>34,450</u>	<u>14</u>
15	<u>23</u>	<u>Inservice Training &amp; Education</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>10,426</u>	<u>0</u>	<u>30,492</u>	<u>279</u>	<u>15</u>
16	<u>25</u>	<u>Travel and Seminar</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>312,259</u>	<u>0</u>	<u>30,492</u>	<u>8,341</u>	<u>16</u>
17	<u>25</u>	<u>Other Admin. Staff Transport</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>83,062</u>	<u>0</u>	<u>30,492</u>	<u>2,219</u>	<u>17</u>
18	<u>26</u>	<u>Insurance-Prop.Liab.Malpractice</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>61,457</u>	<u>0</u>	<u>30,492</u>	<u>1,642</u>	<u>18</u>
19	<u>27</u>	<u>Mgmt Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>227,912</u>	<u>0</u>	<u>30,492</u>	<u>6,088</u>	<u>19</u>
20	<u>30</u>	<u>Depreciation</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>317,964</u>	<u>0</u>	<u>30,492</u>	<u>8,494</u>	<u>20</u>
21	<u>32</u>	<u>Interest</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>176,614</u>	<u>0</u>	<u>30,492</u>	<u>4,718</u>	<u>21</u>
22	<u>33</u>	<u>Real Estate Taxes</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>37,282</u>	<u>0</u>	<u>30,492</u>	<u>996</u>	<u>22</u>
23	<u>34</u>	<u>Rent - Facility &amp; Grounds</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>36,133</u>	<u>0</u>	<u>30,492</u>	<u>965</u>	<u>23</u>
24	<u>35</u>	<u>Rent - Equipment &amp; Vehicles</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>18,933</u>	<u>0</u>	<u>30,492</u>	<u>506</u>	<u>24</u>
25	<b>TOTALS</b>					<b>\$ 4,510,235</b>	<b>\$ 2,239,302</b>		<b>\$ 120,484</b>	<b>25</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

# 0047472

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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

Name of Related Organization Petersen Health Care, Inc.  
 Street Address 830 West Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

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

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	Dietary	Patient Days	427,669	46	\$ 12,081	\$ 11,958	30,492	\$ 861	1
2	2	Food	Patient Days	427,669	46	93	0	30,492	7	2
3	3	Housekeeping	Patient Days	427,669	46	28	0	30,492	2	3
4	4									4
5	5									5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	30,492	1,997	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282	0	30,492	1,018	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	30,492	1,519	8
9	10A	Therapy	Patient Days	427,669	46	0	0	30,492		9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301	0	30,492	521	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	30,492	1,810	11
12	19	Professional Services	Patient Days	427,669	46	54,971	0	30,492	3,919	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088	0	30,492	577	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	30,492	8,762	14
15	23									15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280	0	30,492	804	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003	0	30,492	1,070	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087	0	30,492	78	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265	0	30,492	2,300	19
20	30	Depreciation	Patient Days	427,669	46	23,301	0	30,492	1,661	20
21	32	Interest	Patient Days	427,669	46	373,049	0	30,492	26,598	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282	0	30,492	2,016	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700	0	30,492	406	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479	0	30,492	391	24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 56,317	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cent

# 0047472

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 2,280,000	\$ 2,246,718	09/20/2010	Varies	\$ 185,427	1						
2	Ziegler		X	Mortgage	Varies	09/30/05	430,000	429,213	09/20/2010	0.1000	75,607	2						
3												3						
4									Allocated from Home Office		31,316	4						
5									Interest Income Offset		(4,298)	5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 2,710,000	\$ 2,675,931			\$ 288,052	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,710,000	\$ 2,675,931			\$ 288,052	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' COMPILATION REPORT

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

(See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Fondulac Rehabilitation & Health Care Center COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047472

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 618.283.4262 FAX #: 618.283.4313

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-01-26-300-009</u>	<u>Nursing Home</u>	\$ <u>31,503.00</u>	\$ <u>31,503.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	<u>Home Office Building</u>	\$ _____	\$ <u>3,012.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>31,503.00</u>	\$ <u>34,515.00</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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: 24,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>225,205</u>	<u>2005</u>	<u>\$ 123,750</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>225,205</b>		<b>\$ 123,750</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	2005	1988	\$ 2,164,750	\$ 86,320	25	\$ 86,590	\$ 270	\$ 129,885	4
5										5
6	Home Office Allocation		2006	18,186			796	796	796	6
7										7
8										8
<b>Improvement Type**</b>										
9										9
10										10
11	Original Land Improvements		2005	15,000	1,000	15	1,000		1,500	11
12	Sidewalks		2006	3,200	36	15	107	71	107	12
13	Fire Alarm system		2006	4,030		10	201	201	201	13
14	Replace water main		2006	4,600		25	92	92	92	14
15	Water heater replacement		2006	3,097		10	155	155	155	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	Home Office Allocation- Land Improvement		2006	1,081			100	100	100	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70	
			2,213,944		87,356		89,041	1,685	132,836

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 416,240	\$ 63,994	\$ 61,218	\$ (2,776)	Various	\$ 91,827	71
72	Current Year Purchases	17,697		947	947	Various	947	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			9,259	9,259			74
75	TOTALS	\$ 433,937	\$ 63,994	\$ 71,424	\$ 7,430		\$ 92,774	75

D. Vehicle Depreciation (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	N/A			\$	\$	\$	\$		\$	76
77										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)	\$ 2,771,631	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,350	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 160,465	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,115	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 225,610	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**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	Home Office Allocation				1,371			5
6								6
7	TOTAL				\$ 1,371			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: 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: \$ 22,805 Description: Copier-3944, Dishwasher-853, Nursing Equip 17,725, Misc. office Equip. 283

(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

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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* 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.

**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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</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		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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' COMPILATION 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	10A(3)	hrs	\$	1,353	\$ 111,064	\$	1,353	\$ 111,064	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		531	45,656		531	45,656	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,445	219,733	9,221	2,445	228,954	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				814		814	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Oxygen</b>	39(2)					4,850		4,850	13
14	<b>TOTAL</b>			\$	4,329	\$ 376,453	\$ 14,885	4,329	\$ 391,338	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' COMPILATION REPORT

Facility Name & ID Number **Fondulac Rehabilitation & Health Care Center**

# **0047472**

Report Period Beginning: **01/01/2006**

Ending:

**12/31/2006**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 346,291	\$ 346,291	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	738,217	738,217	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,582	14,582	7
8	Accounts Receivable (owners or related parties)	8,583	8,583	8
9	Other(specify): <u>Education Loans</u>	37	37	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,107,710</b>	<b>\$ 1,107,710</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,306,700	2,337,694	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	433,937	433,937	16
17	Accumulated Depreciation (book methods)	(191,632)	(225,610)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 2,549,005</b>	<b>\$ 2,546,021</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 3,656,715</b>	<b>\$ 3,653,731</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 534,818	\$ 534,818	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,274	34,274	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,791	11,791	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,600	31,600	32
33	Accrued Interest Payable	27,846	27,846	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	18,691	18,691	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 659,020</b>	<b>\$ 659,020</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	429,213	429,213	40
41	Bonds Payable	2,246,718	2,246,718	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Rounding</u>	1		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 2,675,932</b>	<b>\$ 2,675,931</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 3,334,952</b>	<b>\$ 3,334,951</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 321,763</b>	<b>\$ 318,780</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 3,656,715</b>	<b>\$ 3,653,731</b>	<b>48</b>

**Schedule 17A**

Other Current Liabilities

Line 36

	<b>Operating</b>	<b>After Consolidation</b>
Fica W/h & Emplr W/h	5,778	5,778
Federal Withholding	6,288	6,288
State W/h - IL	3,875	3,875
Wage Garnishment	577	577
Tuition Grant	(826)	(826)
Other Payroll Withholdings	2,144	2,144
Other Withholding	(1,092)	(1,092)
Acc Ins - Gen	(1,050)	(1,050)
Accrued Insurance - Health	2997	2,997
	18,691	18,691

Total Line 36

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>44,229</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>44,229</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>277,533</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>1</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>277,534</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>321,763</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION 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**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,032,955	1
2	Discounts and Allowances for all Levels	189,185	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,222,140	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	557,579	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 557,579	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants	117,548	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	179,217	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,839	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 312,604	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	4,298	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,298	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending	1,434	28
28a	Misc Income	513	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,947	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,098,568	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	689,625	31
32	Health Care	1,918,484	32
33	General Administration	504,043	33
	<b>B. Capital Expense</b>		
34	Ownership	465,892	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	189,336	35
36	Provider Participation Fee	53,655	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,821,035	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	277,533	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 277,533	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity is a cash basis taxpayer

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

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

# 0047472

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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	1,993	1,993	\$ 54,470	\$ 27.33	1
2	Assistant Director of Nursing	733	754	36,666	48.63	2
3	Registered Nurses	8,238	8,294	186,335	22.47	3
4	Licensed Practical Nurses	14,041	14,143	328,314	23.21	4
5	CNAs & Orderlies	51,159	51,714	578,876	11.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,077	2,077	31,283	15.06	9
10	Activity Assistants	787	787	11,652	14.81	10
11	Social Service Workers	3,800	3,850	41,538	10.79	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,783	14.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,185	16,263	139,798	8.60	15
16	Dishwashers					16
17	Maintenance Workers	1,899	1,899	24,916	13.12	17
18	Housekeepers	16,130	16,199	137,736	8.50	18
19	Laundry	2,895	2,959	21,187	7.16	19
20	Administrator	1,993	1,993	58,670	29.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,680	3,680	36,881	10.02	23
24	Clerical					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 Care: <u>Care Plan Coordin</u>	3,098	3,122	46,678	14.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,788	131,807	\$ 1,764,783 *	\$ 13.39	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	\$		35
36	Medical Director	Monthly 6,000	9(3)	36
37	Medical Records Consultant	2 200	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,608	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>Rehab Consultant</u>	471 28,235	10A(3)	47
48				48
49	TOTAL (lines 35 - 48)	473 \$ 36,043		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		
Jackie Bowers	Administrator		\$ 58,670	Workers' Compensation Insurance	\$ 37,800	IDPH License Fee	\$ 2,221		
				Unemployment Compensation Insurance	100,565	Advertising: Employee Recruitment	4,488		
				FICA Taxes	131,536	Health Care Worker Background Check (Indicate # of checks performed )			
				Employee Health Insurance	(1,869)	Patient Background Checks	3,260		
				Employee Meals	3,708	Miscellaneous Dues & Subscriptions	1,494		
				Illinois Municipal Retirement Fund (IMRF)*					
				Employee Relations	6,241				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,670			Less: Public Relations Expense	( )		
B. Administrative - Other						Non-allowable advertising	( )		
Description			Amount			Yellow page advertising	( )		
Management fee expense	(Eliminated in Column 7)		\$ 84,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 84,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 277,981	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,463		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Altshuler, Melvoin & Glasser, LLP	Accounting		\$ 1,600				Out-of-State Travel	\$	
SBC	Computer Services		54						
LTC Solutions	Computer Services		530				In-State Travel		
LTC Solutions	Computer Services		1,320						
							Seminar Expense	25	
							Allocated from Home Office	804	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
See Schedule 21A				TOTAL			TOTAL	\$ 829	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,504						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Petersen Health Care, Inc. (Fondulac)  
Provider Number - 0047472  
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

Total (agree to Schedule V, line 19, column 3)

3,504

Allocated from Home Office

Other Professional Fees

9,234

Legal

124

Other Professional Fees - PHO

3,803

Legal - PHO

117

Total (agree to Schedule V, line 19, column 8)

16,782

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2							N/A													
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,628 Line 10A
- (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. \$ 53,655  
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' COMPILATION 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. \$ 3,708 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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? N/A
- 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? 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? Yes  
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees