

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

0047472 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	35,868	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	35,868	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	22,149	3,305	2,500	27,954	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,149	3,305	2,500	27,954	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.94%

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 2,343

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cent # 0047472 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	162,992	14,585		177,577		177,577	4,941	182,518		1
2	Food Purchase		136,860		136,860		136,860	(768)	136,092		2
3	Housekeeping	140,721	25,865		166,586		166,586	37	166,623		3
4	Laundry	13,820	16,109		29,929		29,929	2	29,931		4
5	Heat and Other Utilities			126,460	126,460		126,460	512	126,972		5
6	Maintenance	28,740	10,523	30,276	69,539		69,539	4,537	74,076		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,683	1,683		7
8	TOTAL General Services	346,273	203,942	156,736	706,951		706,951	10,944	717,895		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,276,209	121,765	5,980	1,403,954		1,403,954	8,576	1,412,530		10
10a	Therapy		325	366,697	367,022		367,022		367,022		10a
11	Activities	49,803	1,845	2,545	54,193		54,193	(790)	53,403		11
12	Social Services	38,264	32		38,296		38,296	12	38,308		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,497	1,497		15
16	TOTAL Health Care and Programs	1,364,276	123,967	381,222	1,869,465		1,869,465	9,295	1,878,760		16
	C. General Administration										
17	Administrative	55,460		136,000	191,460		191,460	(94,520)	96,940		17
18	Directors Fees										18
19	Professional Services			4,810	4,810		4,810	8,234	13,044		19
20	Dues, Fees, Subscriptions & Promotions			6,305	6,305		6,305	305	6,610		20
21	Clerical & General Office Expenses	25,554	4,504	9,906	39,964		39,964	55,527	95,491		21
22	Employee Benefits & Payroll Taxes			285,683	285,683		285,683		285,683		22
23	Inservice Training & Education			500	500		500	313	813		23
24	Travel and Seminar			100	100		100	314	414		24
25	Other Admin. Staff Transportation			9,758	9,758		9,758	10,823	20,581		25
26	Insurance-Prop.Liab.Malpractice			57,062	57,062		57,062	231	57,293		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							15,873	15,873		27
28	TOTAL General Administration	81,014	4,504	510,124	595,642		595,642	(2,900)	592,742		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,791,563	332,413	1,048,082	3,172,058		3,172,058	17,339	3,189,397		29

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

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

Facility Name & ID Number

Fondulac Rehabilitation & Health Care Center

#0047472

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			156,198	156,198		156,198	6,148	162,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,169	201,169		201,169	17,514	218,683			32
33	Real Estate Taxes			31,871	31,871		31,871	705	32,576			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,609	34,609		34,609	601	35,210			35
36	Other (specify):*											36
37	TOTAL Ownership			423,847	423,847		423,847	24,968	448,815			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,026		74,026		74,026		74,026			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):* Non-allowable Cost	11,458	1,539	116,116	129,113		129,113	(129,113)				43
44	TOTAL Special Cost Centers	11,458	75,565	169,918	256,941		256,941	(129,113)	127,828			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,803,021	407,978	1,641,847	3,852,846		3,852,846	(86,806)	3,766,040			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(854)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,620)	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	(837)	30		9
10	Interest and Other Investment Income	(268)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	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	(4,593)	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	(96,647)	43		24
25	Fund Raising, Advertising and Promotional	(17,481)	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	(8,793)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (133,168)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	46,362	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 46,362		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,806)		37

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

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

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

Fondulac Rehabilitation & Health Care Center

ID# 0047472

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,448)	43	1
2	X-Rays-Part A	(1,249)	43	2
3	Offset Transportation Revenue	(790)	10	3
4	Disallow Chamber of Commerce Dues	(1,100)	20	4
5	Offset Miscellaneous Office Supplies Revenue	(206)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,793)		49

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	100	See Attached Schedule 6E		See Attached Sch 6E		

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%	\$ 4,941	\$ 4,941	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	81	81	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	512	512	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,019	3,019	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,215	1,215	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	8,575	8,575	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,497	1,497	10
11	V	17 Administrative	136,000	Petersen Health Care, Inc.	100.00%	38,463	(97,537)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,341	4,341	12
13	V							13
14	Total		\$ 136,000			\$ 62,683	\$ * (73,317)	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	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,339	\$	1,339	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	48,267		48,267	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	293		293	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	294		294	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,800		3,800	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	231		231	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,741		13,741	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,259		5,259	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,699		3,699	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	705		705	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	601		601	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		\$			\$ 78,229	\$ *	78,229	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: 1/1/2008Ending: 12/31/2008

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 Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	5	5	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,518	1,518	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	468	468	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1	1	22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	12	12	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	3,017	3,017	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	3,893	3,893	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	66	66	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	7,466	7,466	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	20	20	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	20	20	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	7,023	7,023	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,132	2,132	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,726	1,726	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	14,083	14,083	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 41,450	\$ *	41,450	39

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cen # 0047472 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	1,790,211	1.15	1.92	Salary	38,463	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	\$ 38,463		13

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

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

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

Report Period Beginning:

1/1/2008Ending: 2/31/2008

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 W. 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	Resident Days	1,413,604	69	251,260	250,687	27,954	\$ 4,941	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	27,954	81	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	27,954	37	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	27,954	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	27,954	512	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	27,954	3,019	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	27,954	1,215	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	27,954	8,575	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	27,954	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	27,954	1,497	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	27,954	38,463	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	27,954	4,341	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	27,954	1,339	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	27,954	48,267	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	27,954	293	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	27,954	294	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	27,954	3,800	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	27,954	231	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	27,954	13,741	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	27,954	5,259	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	27,954	3,699	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	27,954	705	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	27,954	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	27,954	601	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 140,912	25

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

0047472

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

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 Operations, LLC
 Street Address 830 W. 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	Resident Days	419,957	23	\$	27,954	\$	1	
2	2	Food	Resident Days	419,957	23	68	27,954	5	2	
3	3	Housekeeping	Resident Days	419,957	23		27,954		3	
4	4	Laundry	Resident Days	419,957	23		27,954		4	
5	5	Utilities	Resident Days	419,957	23		27,954		5	
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	27,954	1,518	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067	27,954	468	7	
8	10	Nursing and Medical Records	Resident Days	419,957	23	6	27,954	1	8	
9	12	Social Services	Resident Days	419,957	23	187	27,954	12	9	
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	27,954	3,017	10
11	19	Professional Services	Resident Days	419,957	23	58,812	27,954	3,893	11	
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997	27,954	66	12	
13	21	Clerical and General Office	Resident Days	419,957	23	112,798	27,954	7,466	13	
14	22	Employee Benefits & Payroll	Resident Days	419,957	23		27,954		14	
15	23	Inservice Training & Education	Resident Days	419,957	23	299	27,954	20	15	
16	24	Travel and Seminar	Resident Days	419,957	23	296	27,954	20	16	
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105	27,954	7,023	17	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23		27,954		18	
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211	27,954	2,132	19	
20	30	Depreciation	Resident Days	419,957	23	26,070	27,954	1,726	20	
21	32	Interest	Resident Days	419,957	23	212,765	27,954	14,083	21	
22	33	Real Estate Taxes	Resident Days	419,957	23		27,954		22	
23	34	Rent-Facility and Grounds	Resident Days	419,957	23		27,954		23	
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23		27,954		24	
25	TOTALS					\$ 626,192	\$ 55,582	\$ 41,450	25	

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		8	9	10					
		Related**					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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 3,100,000	\$ 3,043,482	12/31/13	Varies	\$ 201,169	1				
2												2				
3							Interest Income Offset				(268)	3				
4							Home Office Allocation-PHC				3,699	4				
5							Home Office Allocation-PHO				14,083	5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 3,100,000	\$ 3,043,482			\$ 218,683	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 3,100,000	\$ 3,043,482			\$ 218,683	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.)

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	35,000	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.)	2007	\$	32,871	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,129)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	34,000	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. Home Office Allocation			705	
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.		\$	32,576	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004		9
	2005	31,503	10
	2006	33,455	11
	2007	32,871	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>Long-Term Care Facility</u>	\$ <u>32,871.00</u>	\$ <u>32,871.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>32,871.00</u>	\$ <u>32,871.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 1

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

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

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

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

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

N/A

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	TOTALS	225,205		\$ 123,750	3

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	\$	25	\$ 86,590	\$ 86,590	\$ 303,065	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10	Original Land Improvements		2005	15,000		15	1,000	1,000	3,500	10
11	Sidewalks		2006	3,200		15	213	213	533	11
12	Fire Alarm system		2006	4,030		10	403	403	1,007	12
13	Replace water main		2006	4,600		25	184	184	460	13
14	Water heater replacement		2006	3,097		10	310	310	775	14
15	Cubicle Curtains		2007	5,193		20	260	260	338	15
16	Door Alarm		2007	1,697		15	113	113	226	16
17	Fire Alarm		2007	1,854		15	124	124	248	17
18	Blinds & Valances		2007	4,699		10	470	470	653	18
19	Wallpaper for 3 Halls & Front Lobby		2007	2,258		15	151	151	176	19
20	Painting for all rooms, office area, bathrooms, hallways		2007	13,436		15	896	896	1,288	20
21	Carpeting for Hallways		2007	6,541		15	436	436	602	21
22	Water heater replacement - labor		2008	1,813		7	130	130	130	22
23	Water Heater		2008	11,615		7	830	830	830	23
24	Parking lot resurfacing		2008	34,750		39	446	446	446	24
25										25
26										26
27										27
28	Building Booked				86,320			(86,320)		28
29	Building Improvement Booked				3,599			(3,599)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			966			62	62		32
33	2008-Home Office Allocation-Building Improvements			14,433			346	346		33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

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	TOTAL (lines 4 thru 69)		\$ 2,293,932	\$ 89,919		\$ 92,964	\$ 3,045	\$ 314,277	70

**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	\$ 435,232	\$ 65,410	\$ 62,064	\$ (3,346)		\$ 216,486	71
72	Current Year Purchases	14,810	869	741	(128)		741	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,577	6,577			74
75	TOTALS	\$ 450,042	\$ 66,279	\$ 69,382	\$ 3,103		\$ 217,227	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				\$	\$	\$	\$		\$	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)	\$ 2,867,724	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 156,198	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,346	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,148	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 531,504	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					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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: \$ 13,240 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	Facility	2006 Ford E250	578.17	21,970	18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 21,970	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

Fondulac Rehabilitation and Health Care Center

0047472

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 8,248
Dishwasher	649
Laundry Equipment	59
Copier	3,683
Home Office Allocation	601
	<u>13,240</u>

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	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.

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	\$	10,156	\$ 152,342	\$	10,156	\$ 152,342	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		844	12,662		844	12,662	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		13,231	201,463	325	13,231	201,788	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				74,026		74,026	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			15	220		15	220	12
13	Other (specify):									13
14	TOTAL			\$	24,246	\$ 366,687	\$ 74,351	24,246	\$ 441,038	14

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

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

0047472

Report Period Beginning: **1/1/2008**

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2008**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,107,152	\$ 1,107,152	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,072,520	1,072,520	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,382	24,382	6
7	Other Prepaid Expenses	14,862	14,862	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,218,916	\$ 2,218,916	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	176,700	123,750	13
14	Buildings, at Historical Cost	2,164,750	2,179,183	14
15	Leasehold Improvements, at Historical Cost	47,475	114,749	15
16	Equipment, at Historical Cost	458,697	450,042	16
17	Accumulated Depreciation (book methods)	(501,003)	(531,504)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,346,619	\$ 2,336,220	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,565,535	\$ 4,555,136	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 655,571	\$ 655,571	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,892	38,892	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,488	5,488	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,000	34,000	32
33	Accrued Interest Payable	15,194	15,194	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	33,517	33,517	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 782,662	\$ 782,662	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,043,482	3,043,482	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)	\$ 3,043,482	\$ 3,043,482	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,826,144	\$ 3,826,144	46
47	TOTAL EQUITY(page 18, line 24)	\$ 739,391	\$ 728,992	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,565,535	\$ 4,555,136	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 498,044	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 498,044	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	241,347	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)	\$ 241,347	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)	\$ 739,391	24 *

* This must agree with page 17, line 47.

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,156,899	1
2	Discounts and Allowances for all Levels	220,324	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,377,223	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	546,663	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 546,663	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	854	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	157,932	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,622	20
21	Other Medical Services	2,635	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 169,043	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	268	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 268	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	206	28
28a	Transportation Revenue	790	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 996	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,094,193	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	706,951	31
32	Health Care	1,869,465	32
33	General Administration	595,642	33
	B. Capital Expense		
34	Ownership	423,847	34
	C. Ancillary Expense		
35	Special Cost Centers	203,139	35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,852,846	40
41	Income before Income Taxes (line 30 minus line 40)**	241,347	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 241,347	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. Facility is part of larger entity.

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

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

0047472

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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	2,080	2,080	\$ 57,911	\$ 27.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,636	7,840	207,237	26.43	3
4	Licensed Practical Nurses	17,828	18,072	372,334	20.60	4
5	CNAs & Orderlies	48,839	49,513	536,649	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	26,849	12.91	9
10	Activity Assistants	1,637	1,685	19,530	11.59	10
11	Social Service Workers	2,452	2,452	38,264	15.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,416	16.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,404	14,999	129,576	8.64	15
16	Dishwashers					16
17	Maintenance Workers	1,875	1,914	28,740	15.02	17
18	Housekeepers	15,981	16,422	140,721	8.57	18
19	Laundry	1,745	1,809	13,820	7.64	19
20	Administrator	1,860	1,860	55,460	29.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,026	2,214	25,554	11.54	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	1,827	1,852	19,541	10.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	4,390	4,390	97,419	22.19	33
34	TOTAL (lines 1 - 33)	128,740	131,262	\$ 1,803,021 *	\$ 13.74	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			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,220	10(3)	39
40	Physical Therapy Consultant	1 10	10A(3)	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	1 \$ 7,230		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

Fondulac Rehabilitation & Health Care Center

0047472

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Quality Assurance Nurse	1,167	1,167	24,034	20.59
Care Plan Coordinator	2,467	2,467	58,503	23.71
Marketing	433	433	11,458	26.46
Transportation	323	323	3,424	10.60
TOTAL (lines 1 - 35)	<u>4,390</u>	<u>4,390</u>	<u>97,419</u>	

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	
Morgan Brent	Administrator	0	\$ 49,819	Workers' Compensation Insurance	\$ 45,915	IDPH License Fee	\$ 995	
Justin Yang	Administrator	0	5,641	Unemployment Compensation Insurance	53,798	Advertising: Employee Recruitment		
				FICA Taxes	133,849	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	48,933	Patient Background Checks	156	
				Employee Meals		Miscellaneous Licenses & Permits	350	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,100	
				Employee Relations	3,093	IHCA Dues	2,300	
				Employee Retirement	95	Home Office Allocation	1,405	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,460			Less: Public Relations Expense	(1,100)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 136,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 136,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 285,683	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,610	
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
E-Health Data Solutions	Computer Services		\$ 2,700				Out-of-State Travel	\$
AT&T	Computer Services		495					
LTC Solutions	Computer Services		1,600				In-State Travel	
Misc. Vendors	Computer Services		15					
				N/A				
							Seminar Expense	100
							Home Office Allocation	314
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,810	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 414

* Attach copy of IMRF notifications

**See instructions.

Fondulac Rehabilitation & Health Care Center

0047472

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,810

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	317
GoffWilson, P.A.	Legal	527
Ginoli & Company	Accountants	4,409
RSM McGladrey	Accountants	12
Miscellaneous Vendors	Computer Services	61
Emdeon Business Services	Computer Services	85
Advanced Answers on Demand	Computer Services	997
Access 2 Go	Computer Services	294
Ivans	Computer Services	682
Kemper Technology	Computer Services	540
VisionShare	Computer Services	58
Logmein	Computer Services	42
Comm Net Communiations	Computer Services	15
Charter Communications	Computer Services	13
Advanced System Designs	Computer Services	19
Consolidated Communications	Computer Services	12
Miscellaneous Vendors	Miscellaneous	151

Total (agree to Schedule V, line 19, column 8)	<u>13,044</u>
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Fondulac Rehabilitation & Health Care Center

0047472

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Morgan Brent	Administrator	0	49,819
Justin Yang	Administrator	0	5,641
	Total		<u>55,460</u>

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472Report Period Beginning: 1/1/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 2,300 -IHCA
- (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? No
- (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. \$ 14,804 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? N/A
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. \$ 53,802
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 854
- (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. \$ No
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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 \$5,000, 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