

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

0047472 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	20,219	3,070	5,279	28,568	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,219	3,070	5,279	28,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.87%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 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 2,286

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cent # 0047472 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	177,722	14,198		191,920		191,920	4,996	196,916		1
2	Food Purchase		142,658		142,658		142,658	(2,723)	139,935		2
3	Housekeeping	149,076	34,688		183,764		183,764	47	183,811		3
4	Laundry	14,567	19,064		33,631		33,631		33,631		4
5	Heat and Other Utilities			122,948	122,948		122,948	493	123,441		5
6	Maintenance	32,637	17,745	32,060	82,442		82,442	5,219	87,661		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							902	902		7
8	TOTAL General Services	374,002	228,353	155,008	757,363		757,363	8,934	766,297		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,306,986	118,094	5,137	1,430,217		1,430,217	2,944	1,433,161		10
10a	Therapy			447,968	447,968		447,968		447,968		10a
11	Activities	28,623	1,921	925	31,469		31,469	(1,350)	30,119		11
12	Social Services	36,319			36,319		36,319		36,319		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							372	372		15
16	TOTAL Health Care and Programs	1,371,928	120,015	460,030	1,951,973		1,951,973	1,966	1,953,939		16
	C. General Administration										
17	Administrative	16,288		171,000	187,288		187,288	(98,077)	89,211		17
18	Directors Fees										18
19	Professional Services			33,147	33,147		33,147	8,955	42,102		19
20	Dues, Fees, Subscriptions & Promotions			8,946	8,946		8,946	3,502	12,448		20
21	Clerical & General Office Expenses	26,292	4,857	16,955	48,104		48,104	55,037	103,141		21
22	Employee Benefits & Payroll Taxes			264,429	264,429		264,429		264,429		22
23	Inservice Training & Education			75	75		75	520	595		23
24	Travel and Seminar							160	160		24
25	Other Admin. Staff Transportation			9,610	9,610		9,610	3,012	12,622		25
26	Insurance-Prop.Liab.Malpractice			81,727	81,727		81,727	1,041	82,768		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							19,688	19,688		27
28	TOTAL General Administration	42,580	4,857	585,889	633,326		633,326	(6,162)	627,164		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,788,510	353,225	1,200,927	3,342,662		3,342,662	4,738	3,347,400		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: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			161,451	161,451		161,451	4,436	165,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,352	154,352		154,352	37,965	192,317			32
33	Real Estate Taxes			37,561	37,561		37,561	633	38,194			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,375	22,375		22,375	605	22,980			35
36	Other (specify):*											36
37	TOTAL Ownership			375,739	375,739		375,739	43,639	419,378			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,972		116,972		116,972		116,972			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):* Non-allowable Cost	14,420	1,061	68,649	84,130		84,130	(84,130)				43
44	TOTAL Special Cost Centers	14,420	118,033	122,304	254,757		254,757	(84,130)	170,627			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,802,930	471,258	1,698,970	3,973,158		3,973,158	(35,753)	3,937,405			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	(2,835)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,843)	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	(1,423)	30		9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(203)	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				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	(47,899)	43		24
25	Fund Raising, Advertising and Promotional	(17,647)	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	(16,735)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,600)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	54,847	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 54,847		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (35,753)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Fondulac Rehabilitation & Health Care Center

ID# 0047472

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (9,519)	43	1
2	X-Rays-Part A	(3,301)	43	2
3	Offset Transportation Revenue	(1,350)	11	3
4	Disallow Chamber of Commerce Dues	(480)	20	4
5	Offset Miscellaneous Office Supplies Revenue	(287)	21	5
6	Offset Miscellaneous Nursing Supplies Revenue	(80)	10	6
7	Disallowed Special Events	(469)	43	7
8	Disallowed Pet Expense	(1,249)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,735)		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:	
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)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,996	\$ 4,996	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	112	112	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	47	47	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	493	493	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,420	2,420	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	902	902	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,024	3,024	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%	372	372	10
11	V	17 Administrative	171,000	Petersen Health Care, Inc.	100.00%	72,923	(98,077)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,005	7,005	12
13	V							13
14	Total		\$ 171,000			\$ 92,294	\$ * (78,706)	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%	\$ 1,952	\$ 1,952	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	50,942	50,942	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	520	520	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	160	160	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,510	2,510	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,041	1,041	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,674	13,674	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,118	4,118	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,333	6,333	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	633	633	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%	605	605	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		\$				\$ 82,488	\$ * 82,488	39

* 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	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		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%	2,799	2,799	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,950	1,950	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	2,030	2,030	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	4,382	4,382	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%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	502	502	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%	6,014	6,014	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,741	1,741	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	31,647	31,647	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		\$			\$ 51,065	\$ *	51,065 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: 1/1/2009 Ending: 12/31/2009

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	155,865	1.12	1.86	Salary	\$ 3,248	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	\$ 3,248		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:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	1,493,044	75	\$ 261,102	\$ 259,584	28,568	\$ 4,996	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	28,568	112	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	28,568	47	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	28,568	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	28,568	493	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	28,568	2,420	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	28,568	902	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	28,568	3,024	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	28,568	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	28,568	372	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	28,568	72,923	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	28,568	7,005	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	28,568	1,952	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	28,568	50,942	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	28,568	520	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	28,568	160	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	28,568	2,510	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	28,568	1,041	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	28,568	13,674	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	28,568	4,118	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	28,568	6,333	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	28,568	633	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	28,568	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	28,568	605	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 174,782	25

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center

0047472

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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	399,145	21	\$	\$	28,568	\$	1
2	2	Food	Resident Days	399,145	21			28,568		2
3	3	Housekeeping	Resident Days	399,145	21			28,568		3
4	4	Laundry	Resident Days	399,145	21			28,568		4
5	5	Utilities	Resident Days	399,145	21			28,568		5
6	6	Maintenance	Resident Days	399,145	21	39,101		28,568	2,799	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21			28,568		7
8	10	Nursing and Medical Records	Resident Days	399,145	21			28,568		8
9	12	Social Services	Resident Days	399,145	21			28,568		9
10	17	Administrative	Resident Days	399,145	21		(1)	28,568		10
11	19	Professional Services	Resident Days	399,145	21	27,247		28,568	1,950	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366		28,568	2,030	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225		28,568	4,382	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21			28,568		14
15	23	Inservice Training & Education	Resident Days	399,145	21			28,568		15
16	24	Travel and Seminar	Resident Days	399,145	21			28,568		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018		28,568	502	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21			28,568		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024		28,568	6,014	19
20	30	Depreciation	Resident Days	399,145	21	24,325		28,568	1,741	20
21	32	Interest	Resident Days	399,145	21	442,158		28,568	31,647	21
22	33	Real Estate Taxes	Resident Days	399,145	21			28,568		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21			28,568		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21			28,568		24
25	TOTALS					\$ 713,464	\$		\$ 51,065	25

Facility Name & ID Number

Fondulac Rehabilitation & Health Care Cente

0047472

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 3,100,000	\$ 3,007,428	12/31/13	Varies	\$ 154,352	1							
2												2							
3							Interest Income Offset				(15)	3							
4							Home Office Allocation-PHC				6,333	4							
5							Home Office Allocation-PHO				31,647	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,100,000	\$ 3,007,428			\$ 192,317	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	\$ 3,007,428			\$ 192,317	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.)

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

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	\$ 389,655	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Original Land Improvements	2005		15,000		15	1,000	1,000	4,500	9
10		Sidewalks	2006		3,200		15	213	213	746	10
11		Fire Alarm system	2006		4,030		10	403	403	1,410	11
12		Replace water main	2006		4,600		25	184	184	644	12
13		Water heater replacement	2006		3,097		10	310	310	1,085	13
14		Cubicle Curtains	2007		5,193		20	260	260	598	14
15		Door Alarm	2007		1,697		15	113	113	339	15
16		Fire Alarm	2007		1,854		15	124	124	372	16
17		Blinds & Valances	2007		4,699		10	470	470	1,123	17
18		Wallpaper for 3 Halls & Front Lobby	2007		2,258		15	151	151	327	18
19		Painting for all rooms, office area, bathrooms, hallways	2007		13,436		15	896	896	2,184	19
20		Carpeting for Hallways	2007		6,541		15	436	436	1,038	20
21		Water heater replacement - labor	2008		1,813		7	260	260	390	21
22		Water Heater	2008		11,615		7	1,660	1,660	2,490	22
23		Parking lot resurfacing	2008		34,750		39	892	892	1,338	23
24		Generator Repair	2009		2,599		7	186	186	186	24
25		Compressor Repair	2009		2,971		7	212	212	212	25
26		Freezer Repair	2009		3,445		7	492	492	492	26
27											27
28		Building Booked				86,320			(86,320)		28
29		Building Improvement Booked				4,566			(4,566)		29
30		Land Improvements Booked				2,104			(2,104)		30
31											31
32		2009-Home Office Allocation-Land Improvements			940			59	59		32
33		2009-Home Office Allocation-Building Improvements			14,044			337	337		33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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)		\$ 2,302,532	\$ 92,990		\$ 95,248	\$ 2,258	\$ 409,129	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	\$ 457,056	\$ 65,258	\$ 63,545	\$ (1,713)	10 yrs.	\$ 280,772	71
72	Current Year Purchases	32,627	3,203	1,631	(1,572)	10 yrs.	1,631	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,463	5,463			74
75	TOTALS	\$ 489,683	\$ 68,461	\$ 70,639	\$ 2,178		\$ 282,403	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)	\$ 2,915,965	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,451	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 165,887	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,436	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 691,532	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: \$ 16,042 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	Facility	2006 Ford E250	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* 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 1/1/2009
Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 11,046
Dishwasher	708
Copier	3,683
Home Office Allocation	605
	<u>16,042</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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$	12,034	\$ 180,513	\$	12,034	\$ 180,513	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,887	28,308		1,887	28,308	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		15,936	239,037		15,936	239,037	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				116,972		116,972	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)			7	110		7	110	12
13	Other (specify):									13
14	TOTAL			\$	29,864	\$ 447,968	\$ 116,972	29,864	\$ 564,940	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: **1/1/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (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	\$ 1,420,048	\$ 1,420,048	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>25,000</u>)	993,712	993,712	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,853	48,853	6
7	Other Prepaid Expenses	16,862	16,862	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	31,000	31,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,510,475	\$ 2,510,475	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	2,178,794	14
15	Leasehold Improvements, at Historical Cost	56,489	123,738	15
16	Equipment, at Historical Cost	491,323	489,683	16
17	Accumulated Depreciation (book methods)	(662,453)	(691,532)	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)	\$ 2,226,809	\$ 2,224,433	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,737,284	\$ 4,734,908	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 660,949	\$ 660,949	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)	3,216	3,216	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,300	36,300	32
33	Accrued Interest Payable	13,458	13,458	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	81,145	81,145	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 833,960	\$ 833,960	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,007,428	3,007,428	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)	\$ 3,007,428	\$ 3,007,428	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,841,388	\$ 3,841,388	46
47	TOTAL EQUITY(page 18, line 24)	\$ 895,896	\$ 893,520	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,737,284	\$ 4,734,908	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 739,391	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(25,000)	3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 714,392	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	181,504	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)	\$ 181,504	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)	\$ 895,896	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Fondulac Rehabilitation & Health Care Center**# **0047472**Report Period Beginning: **1/1/2009**Ending: **12/31/2009**

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	\$ 3,481,374	1
2	Discounts and Allowances for all Levels	(223,436)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,257,938	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	684,160	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 684,160	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	2,835	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	191,735	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,267	20
21	Other Medical Services	4,995	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210,832	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	367	28
28a	Transportation Revenue	1,350	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,717	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,154,662	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	757,363	31
32	Health Care	1,951,973	32
33	General Administration	633,326	33
B. Capital Expense			
34	Ownership	375,739	34
C. Ancillary Expense			
35	Special Cost Centers	201,102	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,973,158	40
41	Income before Income Taxes (line 30 minus line 40)**	181,504	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 181,504	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:

1/1/2009

Ending:

12/31/2009

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	\$ 59,483	\$ 28.60	1
2	Assistant Director of Nursing	1,253	1,253	31,582	25.21	2
3	Registered Nurses	5,875	6,171	157,274	25.49	3
4	Licensed Practical Nurses	20,703	21,079	444,976	21.11	4
5	CNAs & Orderlies	49,101	50,724	559,531	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	23,921	11.50	9
10	Activity Assistants	191	191	1,530	8.01	10
11	Social Service Workers	2080	2,080	36,319	17.46	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,447	16.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,203	16,068	143,275	8.92	15
16	Dishwashers					16
17	Maintenance Workers	1,979	2,071	32,637	15.76	17
18	Housekeepers	16,781	17,256	149,076	8.64	18
19	Laundry	1,773	1,833	14,567	7.95	19
20	Administrator	2,102	2,166	85,963	39.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,934	2,082	26,292	12.63	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	1,533	1,589	15,819	9.96	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	2,523	2,643	55,913	21.16	33
34	TOTAL (lines 1 - 33)	129,271	133,446	\$ 1,872,605 *	\$ 14.03	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	1,210	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					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,210		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	127	\$ 3,770	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	127	\$ 3,770		53

Fondulac Rehabilitation & Health Care Center

0047472

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,735	1,791	38,321	21.40
Marketing	481	545	14,420	26.46
Transportation	307	307	3,172	10.33
TOTAL (lines 1 - 35)	2,523	2,643	55,913	

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	
Robert Wilson	Administrator	0	\$ 59,133	Workers' Compensation Insurance	\$ 51,056	IDPH License Fee	\$ 1,990	
Justin Yang	Administrator	0	10,542	Unemployment Compensation Insurance	31,088	Advertising: Employee Recruitment	204	
Amy Morgan	Administrator	0	16,288	FICA Taxes	135,086	Health Care Worker Background Check		
				Employee Health Insurance	45,332	(Indicate # of checks performed)		
				Employee Meals		<u>Patient Background Checks</u>	<u>194</u>	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	832	
				Employee Relations	1,633	Miscellaneous Dues & Subscriptions	480	
				Employee Retirement	144	IHCA Dues	1,500	
				Smoking Cessation Reimbursement	90	Home Office Allocation	3,982	
						Curaspan Medical Group	2,000	
						Less: Public Relations Expense	(480)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 85,963	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 264,429		\$ 12,448		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 171,000				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 171,000				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount	\$			()	
E-Health Data Solutions	Computer Services		\$ 2,700				Home Office Allocation	
AT&T	Computer Services		600				160	
LTC Solutions	Computer Services		1,700				Entertainment Expense	
SimpleLTC, Inc.	Computer Services		81				()	
Heyl, Royster, Voelker, & Allen	Legal Services		21,780				TOTAL (agree to Sch. V, line 24, col. 8)	
Honkamp, Krueger & Co.	Architectural Services		570				\$ 160	
Clifton Gunderson LLP	Accounting Services		5,000					
Medallion Services	Design Services		716					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 33,147	\$				
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Fondulac Rehabilitation & Health Care Center

0047472

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		33,147

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(21)
GoffWilson, P.A.	Legal	64
Jackson Lewis	Legal	502
Peter Gartelos	Legal	48
Misc.	Legal	43
Ginoli & Company	Accountants	3,022
Miscellaneous Vendors	Computer Services	46
Emdeon Business Services	Computer Services	21
Advanced Answers on Demand	Computer Services	2,691
Access 2 Go	Computer Services	259
Ivans	Computer Services	140
Kemper Technology	Computer Services	731
VisionShare	Computer Services	228
MediFax	Computer Services	93
LogmeIn	Computer Services	40
Charter Communications	Computer Services	2
Simple LTC	Computer Services	621
Miscellaneous Vendors	Miscellaneous	425
Total (agree to Schedule V, line 19, column 8)		<u>42,102</u>

Fondulac Rehabilitation & Health Care Center

0047472

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker, and Allen	3,195.00	100%	3,195
Heyl, Royster, Voelker, and Allen	4,705.00	100%	4,705
Heyl, Royster, Voelker, and Allen	8,277.50	100%	8,278
Heyl, Royster, Voelker, and Allen	5,602.15	100%	5,602

Home Office Allocation

Heyl, Royster, Voelker, and Allen	2,414.77	1.87%	45
GoffWilson	3,425.00	1.87%	64
Jackson Lewis	27,043.20	1.87%	502
Peter Gartelos	2,612.50	1.87%	48
Miscellaneous Vendors	2,327.62	1.87%	43

Management Company Allocation

Heyl, Royster, Voelker, and Allen	(927.00)	7.12%	(66)
-----------------------------------	----------	-------	------

Total Legal Fees

22,415

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center# 0047472Report Period Beginning: 1/1/2009Ending: 12/31/2009**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. 1,500 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. \$ 15,025 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. \$ 53,655
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.
- (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. \$ 2,835
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.