



Facility Name & ID Number Fondulac Rehab & Hlth Care C

# 0047472 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,779	2,043	1,449	23,271	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,779	2,043	1,449	23,271	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.06%

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

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     /    /    

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date     /    /     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 1,285

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: 12/31/2015 Fiscal Year: 12/31/2015

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

**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
	<b>A. General Services</b>										
1	Dietary	186,817	14,111	2,280	203,208		203,208	4,510	207,718		1
2	Food Purchase		154,673		154,673		154,673	(1,073)	153,600		2
3	Housekeeping	138,442	31,102		169,544		169,544	35	169,579		3
4	Laundry	132	7,054		7,186		7,186		7,186		4
5	Heat and Other Utilities			84,436	84,436		84,436	260	84,696		5
6	Maintenance	38,994	27,462	27,663	94,119		94,119	1,789	95,908		6
7	Other (specify):* Home Office Ben. Allocation										7
8	<b>TOTAL General Services</b>	<b>364,385</b>	<b>234,402</b>	<b>114,379</b>	<b>713,166</b>		<b>713,166</b>	<b>5,521</b>	<b>718,687</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,082,249	104,845	14,027	1,201,121		1,201,121	(4,140)	1,196,981		10
10a	Therapy		45	221,166	221,211		221,211		221,211		10a
11	Activities	41,195	117	102	41,414		41,414	729	42,143		11
12	Social Services	42,363			42,363		42,363		42,363		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,165,807</b>	<b>105,007</b>	<b>247,295</b>	<b>1,518,109</b>		<b>1,518,109</b>	<b>(3,411)</b>	<b>1,514,698</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			269,300	269,300		269,300	(201,800)	67,500		17
18	Directors Fees										18
19	Professional Services			8,881	8,881		8,881	52,931	61,812		19
20	Dues, Fees, Subscriptions & Promotions			3,245	3,245		3,245	3,103	6,348		20
21	Clerical & General Office Expenses	31,542	1,870	8,232	41,644		41,644	50,496	92,140		21
22	Employee Benefits & Payroll Taxes			212,504	212,504		212,504	27,462	239,966		22
23	Inservice Training & Education			58	58		58	348	406		23
24	Travel and Seminar							79	79		24
25	Other Admin. Staff Transportation			7,648	7,648		7,648	3,549	11,197		25
26	Insurance-Prop.Liab.Malpractice			24,336	24,336		24,336	8,934	33,270		26
27	Other (specify):* Home Office Ben. Allocation										27
28	<b>TOTAL General Administration</b>	<b>31,542</b>	<b>1,870</b>	<b>534,204</b>	<b>567,616</b>		<b>567,616</b>	<b>(54,898)</b>	<b>512,718</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,561,734</b>	<b>341,279</b>	<b>895,878</b>	<b>2,798,891</b>		<b>2,798,891</b>	<b>(52,788)</b>	<b>2,746,103</b>		<b>29</b>

\*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 &amp; ID Number

Fondulac Rehab &amp; Hlth Care C

#0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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	
	<b>D. Ownership</b>											
30	Depreciation			1,847	1,847		1,847	135,040	136,887			30
31	Amortization of Pre-Op. & Org.							8,553	8,553			31
32	Interest							104,259	104,259			32
33	Real Estate Taxes							40,523	40,523			33
34	Rent-Facility & Grounds			318,758	318,758		318,758	(318,758)				34
35	Rent-Equipment & Vehicles			41,582	41,582		41,582	685	42,267			35
36	Other (specify):* Home Office Ben. Allocation											36
37	<b>TOTAL Ownership</b>			362,187	362,187		362,187	(29,698)	332,489			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,669		33,669		33,669		33,669			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,007	186,007		186,007		186,007			42
43	Other (specify):* Home Office Ben. Allocati	6,135	339	165,040	171,514		171,514	(171,514)				43
44	<b>TOTAL Special Cost Centers</b>	6,135	34,008	351,047	391,190		391,190	(171,514)	219,676			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,567,869	375,287	1,609,112	3,552,268		3,552,268	(254,000)	3,298,268			45

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

Facility Name & ID Number Fondulac Rehab & Hlth Care C

# 0047472

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,080)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,862)	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	1,499	30		9
10	Interest and Other Investment Income	(741)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	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	(143,461)	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	(1)	43		24
25	Fund Raising, Advertising and Promotional	(11,729)	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 Page 5A	(10,541)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (175,972)</b>		<b>\$</b>	<b>30</b>

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

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(78,028)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (78,028)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (254,000)</b>		<b>37</b>

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

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

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

Fondulac Rehab & Hlth Care C

ID# 0047472

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (3,432)	43	1
2	X-Rays-Part A	(1,646)	43	2
3	Offset Transportation Revenue	729	11	3
4	Disallowed Pet Expense	(1,082)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(67)	21	5
6	Disallowed Special Events	(245)	43	6
7	Disallowed Chamber of Commerece Dues	(520)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(4,278)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(10,541)	49

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5	
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	227	227	12	
13	V							13	
14	Total		\$			\$ 227	\$ *	227	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 <u>Dues, Fees, Subs &amp; Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 61	\$	61	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	882		882	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			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	<b>Total</b>		\$			\$ 943	\$ *	943	39

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

Facility Name & ID Number Fondulac Rehab & Hlth Care C# 0047472Report Period Beginning: 1/1/2015Ending: 12/31/2015

## 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%	0		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	15 Mgmt. Allocation of Benefits		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%	37,564	37,564	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	3,419	3,419	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(6,353)	(6,353)	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%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	2,345	2,345	33
34	V	31 Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	88	88	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		\$			\$ 37,063	\$ *	37,063 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 Care Management, Inc.	100.00%	\$ 4,510	\$ 4,510
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	7	7
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	35	35
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	260	260
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,789	1,789
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	138	138
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	269,300	Petersen Health Care Management, Inc.	100.00%	67,500	(201,800)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	7,978	7,978
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	143	143
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	50,563	50,563
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	33,815	33,815
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	348	348
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	79	79
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,549	3,549
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	545	545
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	8,100	8,100
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	261	261
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	591	591
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	685	685
39	Total		\$ 269,300			\$ 180,896	\$ * (88,404)

\* 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	19 Professional Services	\$	Fondulac Land		\$ 7,162	\$ 7,162 15
16	V	26 Insurance-Property		Fondulac Land		5,496	5,496 16
17	V	26 Insurance-MIP		Fondulac Land		2,893	2,893 17
18	V	30 Depreciation		Fondulac Land		122,214	122,214 18
19	V	31 Amortization		Fondulac Land		8,553	8,553 19
20	V	32 Interest		Fondulac Land		104,651	104,651 20
21	V	33 Real Estate Taxes		Fondulac Land		39,932	39,932 21
22	V	34 Rent-Income and Grounds	318,758	Fondulac Land			(318,758) 22
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 318,758			\$ 290,901	\$ * (27,857) 39

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

Facility Name &amp; ID Number

Fondulac Rehab &amp; Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name &amp; ID Number

Fondulac Rehab &amp; Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name &amp; ID Number

Fondulac Rehab &amp; Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fondulac Rehab & Hlth Care C # 0047472 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

## 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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Rehab & Hlth Care C

# 0047472 Report Period Beginning: 1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 301,135	\$ 292,840	23,272	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	480	0	23,272	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	23,272	0	3
4	5	Utilities	Resident Days	1,553,881	75	17,327	0	23,272	0	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	23,272	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	23,272	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	23,272	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192	0	23,272	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	23,272	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	23,272	0	10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	23,272	0	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666	0	23,272	227	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548	0	23,272	61	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	23,272	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824	0	23,272	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223	0	23,272	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279	0	23,272	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965	0	23,272	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398	0	23,272	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	23,272	0	20
21	30	Depreciation	Resident Days	1,553,881	75	540,826	0	23,272	882	21
22	32	Interest	Resident Days	1,553,881	75	17,439	0	23,272	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471	0	23,272	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727	0	23,272	0	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 1,170	25

Facility Name & ID Number Fondulac Rehab & Hlth Care C

# 0047472 Report Period Beginning: 1/1/2015

Ending: 2/31/2015

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	210,530	9	\$	\$	23,272	\$	1
2	2	Food	Resident Days	210,530	9			23,272		2
3	3	Housekeeping	Resident Days	210,530	9			23,272		3
4	4	Laundry	Resident Days	210,530	9			23,272		4
5	5	Utilities	Resident Days	210,530	9			23,272		5
6	6	Maintenance	Resident Days	210,530	9			23,272		6
7	7	Mgmt. Allocation of Benefits	Resident Days	210,530	9			23,272		7
8	10	Nursing and Medical Records	Resident Days	210,530	9			23,272		8
9	15	Mgmt. Allocation of Benefits	Resident Days	210,530	9			23,272		9
10	17	Administrative	Resident Days	210,530	9			23,272		10
11	19	Professional Services	Resident Days	210,530	9	339,821		23,272	37,564	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	210,530	9	30,934		23,272	3,419	12
13	21	Clerical and General Office	Resident Days	210,530	9			23,272		13
14	22	Employee Benefits & Payroll	Resident Days	210,530	9	(57,473)		23,272	(6,353)	14
15	23	Inservice Training & Education	Resident Days	210,530	9			23,272		15
16	24	Travel and Seminar	Resident Days	210,530	9			23,272		16
17	25	Other Admin. Staff Transport.	Resident Days	210,530	9			23,272		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	210,530	9			23,272		18
19	30	Depreciation	Resident Days	210,530	9	21,216		23,272	2,345	19
20	31	Amortization	Resident Days	210,530	9			23,272		20
21	32	Interest	Resident Days	210,530	9	795		23,272	88	21
22	33	Real Estate Taxes	Resident Days	210,530	9			23,272		22
23	34	Rent-Facility and Grounds	Resident Days	210,530	9			23,272		23
24	35	Rent-Equipment & Vehicles	Resident Days	210,530	9			23,272		24
25	TOTALS					\$ 335,293	\$		\$ 37,063	25

Facility Name & ID Number Fondulac Rehab & Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 Management, 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	1,553,881	75	\$ 301,135	\$ 332,773	23,272	\$ 4,510	1
2	2	Food	Resident Days	1,553,881	75	480		23,272	7	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,687	23,272	35	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		23,272	260	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	100,000	23,272	1,789	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			23,272		6
7	9	Medical Director	Resident Days	1,553,881	75			23,272		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		23,272	138	8
9	10A	Therapy	Resident Days	1,553,881	75			23,272		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			23,272		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	5,404,166	23,272	67,500	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		23,272	7,978	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		23,272	143	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,458,155	23,272	50,563	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		23,272	33,815	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		23,272	348	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		23,272	79	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		23,272	3,549	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		23,272	545	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			23,272		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		23,272	8,100	21
22	32	Interest	Resident Days	1,553,881	75	17,439		23,272	261	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		23,272	591	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		23,272	685	24
25	TOTALS					\$ 12,370,446	\$ 9,297,781		\$ 180,896	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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	First Merit		X	Mortgage	Varies	9/15/14	\$ 2,799,200	\$ 2,702,631	12/31/34	Varies	\$ 105,527	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 2,799,200	\$ 2,702,631			\$ 105,527	9					
<b>B. Non-Facility Related*</b>																	
10											(1,617)	10					
11											88	11					
12											261	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (1,268)	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 2,799,200	\$ 2,702,631			\$ 104,259	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 2,893 Line # 26

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2014 report.		\$	<b>41,712</b>		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.)		\$	<b>40,222</b>		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,490)</b>		3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>41,422</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>591</b>	<b>Home Office Allocation</b>	6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>40,523</b>		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<b>37,082</b>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2014 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2011	<b>36,768</b>	9												
	2012	<b>40,240</b>	10												
	2013	<b>40,501</b>	11												
	2014	<b>40,222</b>	12												
<b>Accrual based on prior year tax bill.</b>															

**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.**



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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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: 188,175 2. Number of Years Over Which it is Being Amortized: 20  
 3. Current Period Amortization: 8,553 4. Dates Incurred: 2013-2014

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	2005	1988	\$ 2,164,750	\$	25	\$ 86,590	\$ 86,590	\$ 909,195	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Original Land Improvements	2005		15,000		15	1,000	1,000	10,500	9
10	Sidewalks	2006		3,200		15	213	213	2,024	10
11	Fire Alarm system	2006		4,030		10	403	403	3,828	11
12	Replace water main	2006		4,600		25	184	184	1,748	12
13	Water heater replacement	2006		3,097		10	310	310	2,945	13
14	Cubicle Curtains	2007		5,193		20	260	260	2,158	14
15	Door Alarm	2007		1,697		15	113	113	1,017	15
16	Fire Alarm	2007		1,854		15	124	124	1,116	16
17	Blinds & Valances	2007		4,699		10	470	470	3,943	17
18	Wallpaper for 3 Halls & Front Lobby	2007		2,258		15	151	151	1,233	18
19	Painting for all rooms, office area, bathrooms, hallways	2007		13,436		15	896	896	7,560	19
20	Carpeting for Hallways	2007		6,541		15	436	436	3,654	20
21	Water heater replacement - labor	2008		1,813		7	123	123	1,813	21
22	Water Heater	2008		11,615		7	825	825	11,615	22
23	Parking lot resurfacing	2008		34,750		39	892	892	6,690	23
24	Generator Repair	2009		2,599		7	372	372	2,418	24
25	Compressor Repair	2009		2,971		7	424	424	2,756	25
26	Freezer Repair	2009		3,445		7	493	493	3,445	26
27	Landscaping	2010		4,850		15	324	324	1,782	27
28	Cabinetry-Nursing Stations	2010		14,218		15	948	948	5,214	28
29	Carpet and Tiling in Nursing Stations and Kitchen	2010		15,811		15	1,054	1,054	5,797	29
30	Water Softener	2011		2,974		7	424	424	1,696	30
31	Water Heater	2011		5,737		7	820	820	3,280	31
32	Water Heater	2011		2,989		7	428	428	1,712	32
33	Tile Replacement in Showers	2011		15,567		15	1,038	1,038	4,152	33
34	Roof Replacement on North Section	2011		49,142		25	1,966	1,966	8,847	34
35	Water Main Repair	2012		3,602		7	514	514	1,799	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

Facility Name &amp; ID Number Fondulac Rehab &amp; Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Line Repair	2013	\$ 10,932	\$	7	\$ 1,562	\$ 1,562	\$ 3,905	37
38	Bathroom Fixtures	2013	2,809		7	402	402	1,005	38
39	Blacktopping	2013	10,500		7	1,500	1,500	3,750	39
40	Painting-Exterior	2013	11,071		15	738	738	1,845	40
41	Alarm System Panel Replacement	2013	4,273		7	610	610	1,525	41
42	Tile Replacement in Hallways and Kitchen	2014	13,185		15	879	879	1,319	42
43	Landscaping Around Building	2014	21,897		15	1,460	1,460	2,190	43
44	Landscaping Around Building	2014	8,944		15	596	596	894	44
45	Copper Line Repair	2015	3,241		7	232	232	232	45
46	Nurses Station Replacement	2015	8,982		7	642	642	642	46
47	Plumbing Repairs	2015	9,170		7	655	655	655	47
48	Water Softener Replacement	2015	6,126		7	438	438	438	48
49	Dumpster Pads	2015	19,686		15	656	656	656	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	Land Improvements Booked			2,428			(2,428)		63
64	Building Booked			86,320			(86,320)		64
65	Building Improvement Booked			21,504			(21,504)		65
66									66
67	2015-Home Office Allocation-Building Improvements		10,183			244	244		67
68	2015-Home Office Allocation-Land Improvements		951			61	61		68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,544,388	\$ 110,252		\$ 112,469	\$ 2,217	\$ 1,032,992	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 129,356	\$ 13,414	\$ 12,937	\$ (477)	5-10 yrs.	\$ 72,410	71
72	Current Year Purchases	9,173	395	459	64	10 yrs.	459	72
73	Fully Depreciated Assets	416,240					416,240	73
74	Home Office Allocation			11,022	11,022			74
75	TOTALS	\$ 554,769	\$ 13,809	\$ 24,418	\$ 10,609		\$ 489,109	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,222,907	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,887	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,826	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,522,101	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.

Facility Name & ID Number Fondulac Rehab & Hlth Care C

# 0047472

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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: \$ 35,329 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	<u>FACILITY</u>	<u>FORD 2012 E150</u>	\$ <u>578.00</u>	\$ <u>6,938</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>578.00</b>	\$ <b>6,938</b>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**Fondulac Rehab & Hlth Care C  
0047472**

**Period Beginning**     1/1/2015  
**Period End**            12/31/2015

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 22,335
Dishwasher	776
Copier	11,533
Home Office Allocation	685
	<u>35,329</u>

Facility Name & ID Number Fondulac Rehab & Hlth Care C # 0047472 Report Period Beginning: 1/1/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**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	\$	6,722	\$ 100,834	\$	6,722	\$ 100,834	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,307	19,603		1,307	19,603	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,715	100,729	45	6,715	100,774	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				33,669		33,669	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	14,744	\$ 221,166	\$ 33,714	14,744	\$ 254,880	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 Rehab & Hlth Care C**# **0047472**Report Period Beginning: **1/1/2015**

Ending:

**12/31/2015****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2015**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (579,425)	\$ (579,425)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>263,710</u> )	1,279,041	1,279,041	3
4	Supply Inventory (priced at <u>Cost</u> )	16,862	16,862	4
5	Short-Term Investments			5
6	Prepaid Insurance	31,174	46,094	6
7	Other Prepaid Expenses	13,101	38,849	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	1,688	1,688	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 762,441	\$ 803,109	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		123,750	13
14	Buildings, at Historical Cost		2,174,933	14
15	Leasehold Improvements, at Historical Cost	8,944	369,455	15
16	Equipment, at Historical Cost	10,386	554,769	16
17	Accumulated Depreciation (book methods)	(2,046)	(1,522,101)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	(2)	188,173	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,692)	20
21	Restricted Funds		380,564	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 17,282	\$ 2,258,851	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 779,723	\$ 3,061,960	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 839,040	\$ 900,031	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,300	91,300	30
31	Accrued Taxes Payable (excluding real estate taxes)	83,734	83,734	31
32	Accrued Real Estate Taxes(Sch.IX-B)		41,422	32
33	Accrued Interest Payable		8,671	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	197,308	197,308	36
37	<u>Accrued Management Fees</u>	25,651	25,651	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,237,033	\$ 1,348,117	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,702,631	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Intercompany Loans</u>	656,655	76,559	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 656,655	\$ 2,779,190	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,893,688	\$ 4,127,307	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,113,965)	\$ (1,065,347)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 779,723	\$ 3,061,960	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,359,111)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	33,473	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,325,638)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	211,673	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)	\$ 211,673	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,113,965)	24 *

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

Facility Name & ID Number Fondulac Rehab & Hlth Care C# 0047472Report Period Beginning: 1/1/2015Ending: 12/31/2015

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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,458,448	1
2	Discounts and Allowances for all Levels	(172,916)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,285,532	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	407,984	6
7	Oxygen	398	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 408,382	8
<b>C. Other Operating Revenue</b>			
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	1,080	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,542	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	154	19
20	Radiology and X-Ray	5,112	20
21	Other Medical Services	2,782	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 65,670	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	741	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 741	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Transportation Revenue</b>	(729)	28
28a	<b>Miscellaneous Revenue</b>	4,345	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,616	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,763,941	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	713,166	31
32	Health Care	1,518,109	32
33	General Administration	567,616	33
<b>B. Capital Expense</b>			
34	Ownership	362,187	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	205,183	35
36	Provider Participation Fee	186,007	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,552,268	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	211,673	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 211,673	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,629,254	44
45	Private Pay - Net Inpatient Revenue	372,198	45
46	Medicare - Net Inpatient Revenue	252,963	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	35,848	47
48	Other-(specify) <u>Charity Therapy Allowance</u>	(4,731)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,285,532	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Fondulac Rehab & Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

**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	\$ 71,680	\$ 34.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,666	9,095	232,706	25.59	3
4	Licensed Practical Nurses	12,629	12,969	266,822	20.57	4
5	CNAs & Orderlies	39,280	40,144	451,553	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,781	1,805	24,423	13.53	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	42,363	20.37	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	39,471	18.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,763	13,672	147,346	10.78	15
16	Dishwashers					16
17	Maintenance Workers	2,070	2,134	38,994	18.27	17
18	Housekeepers	13,749	14,156	138,442	9.78	18
19	Laundry	15	15	132	8.80	19
20	Administrator	2,080	2,080	67,500	32.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,918	1,974	31,542	15.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,035	2,035	59,488	29.23	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	1,839	1,948	22,907	11.76	33
34	TOTAL (lines 1 - 33)	105,065	108,267	\$ 1,635,369 *	\$ 15.10	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	40	\$ 2,280	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,036	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	\$ 19,316		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	209	\$ 6,936	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	209	\$ 6,936		53

Fondulac Rehab & Hlth Care C  
 0047472  
 Period Beginning 1/1/2015  
 Period End 12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Transportation	1,452	1,561	16,772	10.74
Marketing	387	387	6,135	15.85
<b>TOTAL</b>	<u>1,839</u>	<u>1,948</u>	<u>22,907</u>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Doug Harridge	Administrator	0	\$ 67,500	Workers' Compensation Insurance	\$ 50,201	IDPH License Fee	\$		
				Unemployment Compensation Insurance	44,845	Advertising: Employee Recruitment		289	
				FICA Taxes	113,473	Health Care Worker Background Check			
				Employee Health Insurance	2,593	(Indicate # of checks performed <u>94</u> )		1,336	
				Employee Meals		Miscellaneous Licenses & Permits		1,100	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions		520	
				Employee Relations	1,392	Home Office Allocation		3,623	
				Home Office Allocation	27,462				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,500						
B. Administrative - Other									
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 269,300						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 269,300						
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**		
E-Health Data Solutions	Computer Services		\$ 4,487				Out-of-State Travel	\$	
Peoria County Circuit Clerk	Filing Fees		60						
Comcast Cable	Computer Services		1,131				In-State Travel		
Sorling Northrup	Legal Services		132	N/A					
Pro Title USA	Filing Fees		152				Seminar Expense		
Honkamp Krueger & Co.	Accounting Services		2,919				Home Office Allocation	79	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,881	TOTAL		\$	Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 79	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Fondulac Rehab & Hlth Care C  
0047472**

**Period Beginning**

**1/1/2015**

**Period End**

**12/31/2015**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		8,881

**Home Office Allocation**

Denton's US LLP	Legal	113
Applegate and Thorne	Legal	17
Miller Hall and Triggs	Legal	17
Healthcare Resources International	Legal	93
Lexis Nexis	Legal	7
GoffWilson	Legal	776
Illinois Secretary of State	Legal	28
Edgerton and Edgerton	Legal	122
Black, Hedin, Ballard, McDonald	Legal	104
Cole Schotz LLC	Legal	274
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	1,211
Ginoli & Co.	Accountants	7,740
Miscellaneous	Computer Services	95
CCH	Computer Services	14
PTC Select	Computer Services	18
Advanced Answers on Demand	Computer Services	2484
Stratus Networks	Computer Services	452
Kemper Technology	Computer Services	664
AT&T	Computer Services	6
Ability Network	Computer Services	640
CIAN	Computer Services	450
Comcast	Computer Services	17
Emdeon	Computer Services	37
Charter Communications	Computer Services	31

Allscripts	Computer Services	22
Allpayer Exchange	Computer Services	14
E-Health Technologies	Computer Services	10
Macquarie Technology Services	Computer Services	15
Optimizer	Other Prof Fees	43
D.J. Howard Appraisers	Other Prof Fees	40
Key Corporate Services	Other Prof Fees	132
Consolidated Land Surveying	Other Prof Fees	83
Alan Litwiller	Other Prof Fees	17
Registered Agent Solutions	Other Prof Fees	25
Duane Morris LLP	Other Prof Fees	6954
Marotta Gund Budd & Derza	Other Prof Fees	29956

Total (agree to Schedule V, line 19, column 8)	<u>61,852</u>
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**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Fondulac Rehab &amp; Hlth Care C

# 0047472

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,930 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 186,007  
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. \$ 1,080
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ (751)
- 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.