FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0047472

Facility Name: Fondulac Rehabilitation & Health Care Center

Address: 901 Illini Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 694-6446 Fax # (309) 694-4425

HFS ID Number:

Date of Initial License for Current Owners: 10/01/05

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	
(Signed)	(Date)
(Type or Print Name)	Mark B. Petersen
(Title)	Chief Executive Officer

Paid Preparer	
(Signed)	(Date)
(Print Name and Title)	
(Firm Name & Address)	
(Telephone) ( )	Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,756	2,290	2,638	26,684	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,756	2,290	2,638	26,684	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.60%

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 [X] 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 [X]

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 [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 2,430

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cent # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,044	12,624		205,668		205,668	4,970	210,638			1
2	Food Purchase		145,091		145,091		145,091	(3,367)	141,724			2
3	Housekeeping	165,648	32,942		198,590		198,590	59	198,649			3
4	Laundry	570	17,124		17,694		17,694		17,694			4
5	Heat and Other Utilities			116,829	116,829		116,829	494	117,323			5
6	Maintenance	41,184	21,283	31,280	93,747		93,747	2,893	96,640			6
7	Other (specify):* Home Off. Ben. All.							1,165	1,165			7
8	**TOTAL General Services**	400,446	229,064	148,109	777,619		777,619	6,214	783,833			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,315,482	123,374	500	1,439,356		1,439,356	76	1,439,432			10
10a	Therapy			352,427	352,427		352,427		352,427			10a
11	Activities	37,978	1,882	(2,737)	37,123		37,123	(3,915)	33,208			11
12	Social Services	37,069			37,069		37,069		37,069			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	1,390,529	125,256	356,190	1,871,975		1,871,975	(3,839)	1,868,136			16
	C. General Administration											
17	Administrative	13,468		294,000	307,468		307,468	(190,310)	117,158			17
18	Directors Fees											18
19	Professional Services			8,112	8,112		8,112	6,683	14,795			19
20	Dues, Fees, Subscriptions & Promotions			7,696	7,696		7,696	2,016	9,712			20
21	Clerical & General Office Expenses	27,108	4,857	14,780	46,745		46,745	50,950	97,695			21
22	Employee Benefits & Payroll Taxes			301,937	301,937		301,937	4,304	306,241			22
23	Inservice Training & Education			1,095	1,095		1,095	355	1,450			23
24	Travel and Seminar							41	41			24
25	Other Admin. Staff Transportation			12,254	12,254		12,254	4,452	16,706			25
26	Insurance-Prop.Liab.Malpractice			37,878	37,878		37,878	738	38,616			26
27	Other (specify):* Home Off. Ben. All.							20,187	20,187			27
28	**TOTAL General Administration**	40,576	4,857	677,752	723,185		723,185	(100,584)	622,601			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,831,551	359,177	1,182,051	3,372,779		3,372,779	(98,209)	3,274,570			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:** 1/1/2010 **Ending:** 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			164,969	164,969		164,969	5,802	170,771			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,619	150,619		150,619	35,643	186,262			32
33	Real Estate Taxes			38,604	38,604		38,604	(662)	37,942			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,807	25,807		25,807	683	26,490			35
36	Other (specify):*											36
37	**TOTAL Ownership**			379,999	379,999		379,999	41,466	421,465			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,720		89,720		89,720		89,720			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		376	54,529	54,905		54,905	(54,905)				43
44	**TOTAL Special Cost Centers**		90,096	108,184	198,280		198,280	(54,905)	143,375			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,831,551	449,273	1,670,234	3,951,058		3,951,058	(111,648)	3,839,410			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 Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,367)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,045)	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	(1,240)	30		9
10	Interest and Other Investment Income	(84)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(211)	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	(34,625)	43		24
25	Fund Raising, Advertising and Promotional	(3,449)	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	(19,074)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,095)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,553)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (45,553)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (111,648)		37

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

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

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

BHF USE ONLY									
48		49		50		51		52	

STATE OF ILLINOIS

Fondulac Rehabilitation & Health Care Center

ID# 0047472

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (12,662)	43	1
2	X-Rays-Part A	3,266	43	2
3	Offset Transportation Revenue	(3,915)	11	3
4	Disallow Chamber of Commerce Dues	(480)	20	4
5	Offset Miscellaneous Office Supplies Revenue	(736)	21	5
6	Disallow Contributions	(175)	43	6
7	Disallowed Special Events	(1,988)	43	7
8	Disallowed Pet Expense	(1,016)	43	8
9	Disallow Real Estate Tax penalty	(1,368)	33	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
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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**	(19,074)		49

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 B. 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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 4,970	$ 4,970	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	59	59	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	494	494	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,893	2,893	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,165	1,165	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	76	76	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	294,000	Petersen Health Care, Inc.	100.00%	103,690	(190,310)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,507	5,507	12
13	V								13
14	Total			$ 294,000			$ 118,854	$ * (175,146)	14

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	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 & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 1,364	$ 1,364	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	49,470	49,470	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	355	355	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	41	41	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,452	4,452	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	738	738	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	20,187	20,187	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,726	5,726	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,598	6,598	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	706	706	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	683	683	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			$			$ 90,320	$ * 90,320	39

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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	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%	1,176	1,176	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	1,132	1,132	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,216	2,216	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	4,304	4,304	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	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	1,316	1,316	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	29,129	29,129	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			$			$ 39,273	$ * 39,273	39

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cent # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mark Petersen	President	Administrative	100.00	178,860	1.02	1.70	Salary	$ 3,390	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,390		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: 1/1/2010 Ending: 2/31/2010

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 X 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,527,029	77	$ 284,427	$ 283,010	26,684	$ 4,970	1
2	2	Food	Resident Days	1,527,029	77	0	0	26,684	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	26,684	59	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	26,684	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	26,684	494	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	26,684	2,893	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	26,684	1,165	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	26,684	76	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	26,684	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	26,684	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	26,684	103,690	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	26,684	5,507	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	26,684	1,364	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	26,684	49,470	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	26,684	355	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	26,684	41	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	26,684	4,452	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	26,684	738	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	26,684	20,187	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	26,684	5,726	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	26,684	6,598	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	26,684	706	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	26,684	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	26,684	683	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 209,174	25

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	389,552	21	$	$	26,684	$	1
2	2	Food	Resident Days	389,552	21			26,684		2
3	3	Housekeeping	Resident Days	389,552	21			26,684		3
4	4	Laundry	Resident Days	389,552	21			26,684		4
5	5	Utilities	Resident Days	389,552	21			26,684		5
6	6	Maintenance	Resident Days	389,552	21			26,684		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21			26,684		7
8	10	Nursing and Medical Records	Resident Days	389,552	21			26,684		8
9	12	Social Services	Resident Days	389,552	21			26,684		9
10	17	Administrative	Resident Days	389,552	21			26,684		10
11	19	Professional Services	Resident Days	389,552	21	17,164		26,684	1,176	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534		26,684	1,132	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356		26,684	2,216	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830		26,684	4,304	14
15	23	Inservice Training & Education	Resident Days	389,552	21			26,684		15
16	24	Travel and Seminar	Resident Days	389,552	21			26,684		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21			26,684		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21			26,684		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21			26,684		19
20	30	Depreciation	Resident Days	389,552	21	19,207		26,684	1,316	20
21	32	Interest	Resident Days	389,552	21	425,239		26,684	29,129	21
22	33	Real Estate Taxes	Resident Days	389,552	21			26,684		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21			26,684		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21			26,684		24
25	TOTALS					$ 573,330	$		$ 39,273	25

Facility Name & ID Number Fondulac Rehabilitation & Health Care Cente # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/19/07	$ 3,100,000	$ 2,971,373	12/31/13	Varies	$ 150,619	1
2												2
3							Interest Income Offset				(84)	3
4							Home Office Allocation-PHC				6,598	4
5							Home Office Allocation-PHO				29,129	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,100,000	$ 2,971,373			$ 186,262	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	$ 2,971,373			$ 186,262	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.)

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2009 report.		$ 36,300	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.)	2009	$ 36,216	2
3. Under or (over) accrual (line 2 minus line 1).		$ (84)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,320	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation	$ 706	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 37,942	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2005	31,503	8
	2006	33,455	9
	2007	32,871	10
	2008	35,261	11
	2009	36,216	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

Line	Description	Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fondulac Rehabilitation & Health Care Center COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047472

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-26-300-009	Long-Term Care Facility	$ 36,215.48	$ 36,215.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,215.48	$ 36,215.48

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	225,205	2005	$ 123,750	1
2					2
3	TOTALS	225,205		$ 123,750	3

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2005	1988	$ 2,164,750	$	25	$ 86,590	$ 86,590	$ 476,245	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	5,500	9
10	Sidewalks			2006	3,200		15	213	213	959	10
11	Fire Alarm system			2006	4,030		10	403	403	1,813	11
12	Replace water main			2006	4,600		25	184	184	828	12
13	Water heater replacement			2006	3,097		10	310	310	1,395	13
14	Cubicle Curtains			2007	5,193		20	260	260	858	14
15	Door Alarm			2007	1,697		15	113	113	452	15
16	Fire Alarm			2007	1,854		15	124	124	496	16
17	Blinds & Valances			2007	4,699		10	470	470	1,593	17
18	Wallpaper for 3 Halls & Front Lobby			2007	2,258		15	151	151	478	18
19	Painting for all rooms, office area, bathrooms, hallways			2007	13,436		15	896	896	3,080	19
20	Carpeting for Hallways			2007	6,541		15	436	436	1,474	20
21	Water heater replacement - labor			2008	1,813		7	260	260	650	21
22	Water Heater			2008	11,615		7	1,660	1,660	4,150	22
23	Parking lot resurfacing			2008	34,750		39	892	892	2,230	23
24	Generator Repair			2009	2,599		7	372	372	558	24
25	Compressor Repair			2009	2,971		7	424	424	636	25
26	Freezer Repair			2009	3,445		7	492	492	984	26
27	Landscaping			2010	4,850		15	162	162	162	27
28	Cabinetry-Nursing Stations			2010	14,218		15	474	474	474	28
29	Carpet and Tiling in Nursing Stations and Kitchen			2010	15,811		15	527	527	527	29
30											30
31	Land Improvements Booked					2,212			(2,212)		31
32	Building Booked					86,320			(86,320)		32
33	Building Improvement Booked					5,629			(5,629)		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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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	2010-Home Office Allocation-Building Improvements		12,826			308	308		66
67	2010-Home Office Allocation-Land Improvements		1,197			67	67		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,336,450	$ 94,161		$ 96,788	$ 2,627	$ 505,542	70

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 489,683	$ 69,919	$ 66,808	$ (3,111)	10 yrs.	$ 349,211	71
72	Current Year Purchases	10,166	889	508	(381)	10 yrs.	508	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,667	6,667			74
75	TOTALS	$ 499,849	$ 70,808	$ 73,983	$ 3,175		$ 349,719	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)	$ 2,960,049	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,969	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 170,771	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,802	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 855,261	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	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number: Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 19,552 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

* 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 & Health Care Center
0047472
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$ 12,772
Dishwasher	708
Copier	5,389
Home Office Allocation	683
	19,552

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

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

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.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	8,345	$ 125,171	$	8,345	$ 125,171	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,016	45,240		3,016	45,240	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,120	181,796		12,120	181,796	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				89,720		89,720	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(3)			15	220		15	220	12
13	Other (specify):									13
14	TOTAL			$	23,496	$ 352,427	$ 89,720	23,496	$ 442,147	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: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,718,231	$ 1,718,231	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 25,000)	522,484	522,484	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,582	25,582	6
7	Other Prepaid Expenses	16,862	16,862	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Mgmt. Fees	45,000	45,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,328,159	$ 2,328,159	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,550	123,750	13
14	Buildings, at Historical Cost	2,164,750	2,177,576	14
15	Leasehold Improvements, at Historical Cost	86,519	158,874	15
16	Equipment, at Historical Cost	501,489	499,849	16
17	Accumulated Depreciation (book methods)	(827,423)	(855,261)	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)**	$ 2,106,885	$ 2,104,788	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,435,044	$ 4,432,947	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 535,330	$ 535,330	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)	16,941	16,941	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,320	37,320	32
33	Accrued Interest Payable	13,311	13,311	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	28,916	28,916	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 670,710	$ 670,710	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,971,373	2,971,373	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)**	$ 2,971,373	$ 2,971,373	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,642,083	$ 3,642,083	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 792,961	$ 790,864	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,435,044	$ 4,432,947	48

*(See instructions.)

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 895,896	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 895,893	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(102,932)	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)**	$ (102,932)	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)**	$ 792,961	24 *

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

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,435,997	1
2	Discounts and Allowances for all Levels	(241,906)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,194,091	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,392	6
7	Oxygen	1,322	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 491,714	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	3,367	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	140,209	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,738	20
21	Other Medical Services	6,272	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 157,586	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	84	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 84	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Revenue	736	28
28a	Transportation Revenue	3,915	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,651	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,848,126	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	777,619	31
32	Health Care	1,871,975	32
33	General Administration	723,185	33
	B. Capital Expense		
34	Ownership	379,999	34
	C. Ancillary Expense		
35	Special Cost Centers	144,625	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)***	$ 3,951,058	40
41	**Income before Income Taxes (line 30 minus line 40)****	(102,932)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (102,932)	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: 1/1/2010 Ending: 12/31/2010

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	2,420	2,420	$ 73,449	$ 30.35	1
2	Assistant Director of Nursing	2,229	2,231	57,490	25.77	2
3	Registered Nurses	8,545	8,782	229,932	26.18	3
4	Licensed Practical Nurses	16,195	17,048	359,345	21.08	4
5	CNAs & Orderlies	47,021	48,529	534,607	11.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,837	1,856	20,898	11.26	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	37,069	17.82	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,072	16.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,088	15,817	157,972	9.99	15
16	Dishwashers					16
17	Maintenance Workers	2,606	2,763	41,184	14.91	17
18	Housekeepers	18,570	18,916	165,648	8.76	18
19	Laundry	68	68	570	8.38	19
20	Administrator	2,080	2,080	100,300	48.22	20
21	Assistant Administrator	780	780	13,468	17.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,934	2,084	27,108	13.01	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	1,688	1,728	16,891	9.77	31
32	Other Health C: Care Plan Coord	2,080	2,080	43,768	21.04	32
33	Other(specify) Transportation	1,644	1,644	17,080	10.39	33
34	TOTAL (lines 1 - 33)	128,945	132,986	$ 1,931,851 *	$ 14.53	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	4,226	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)		$ 10,226		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	72	2,074	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	72	$ 2,074		53

Fondulac Rehabilitation & Health Care Center

Period Beginning 1/1/2010
Period End 12/31/2010

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				#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation				#DIV/0!
Marketing				#DIV/0!
TOTAL				

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Wilson	Administrator	0	$ 100,300
Lance Tossell	Asst Admin.	0	13,468
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 113,768

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 294,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 294,000

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,420
AT&T	Computer Services	600
Tazewell County Circuit Clerk	Legal Services	216
Tazewell County Sheriff	Legal Services	30
Heyl, Royster, Voelker, & Allen	Legal Services	1,257
Dennis Sheehan	Legal Services	1,726
Honkamp Krueger	Accounting	863
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,112

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,142
Unemployment Compensation Insurance	33,161
FICA Taxes	136,917
Employee Health Insurance	88,098
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,005
Employee Retirement	398
Life Insurance	216
Home Office Allocation	4,304
TOTAL (agree to Schedule V, line 22, col.8)	$ 306,241

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

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		1,083
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks	135	1,350
Miscellaneous Licenses & Permits		918
Miscellaneous Dues & Subscriptions		480
IHCA Dues		1,300
Home Office Allocation		2,496
Curaspan Health Group		2,565
Less: Public Relations Expense		(480)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 9,712

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	41
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 41

* Attach copy of IMRF notifications

**See instructions.

Fondulac Rehabilitation & Health Care Center
0047472
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,112
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	5
Healthcare Resources International	Legal	68
Ginoli & Company	Accountants	2,150
Bank of America	Accountants	214
Miscellaneous Vendors	Computer Services	31
VisionShare	Computer Services	293
Advanced Answers on Demand	Computer Services	1,841
Access 2 Go	Computer Services	299
Kemper Technology	Computer Services	254
MediFax	Computer Services	105
LogmeIn	Computer Services	75
Simple LTC	Computer Services	1,174
Optimizer Systems	Other Professional I	42
Clifton Gunderson	Other Professional I	132
Total (agree to Schedule V, line 19, column 8)		14,795

Period Beginning **1/1/2010**
Period End **12/31/2010**

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
Home Office Allocation			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
Total Legal Fees			-

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

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

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. **1,300** **IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **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. $ **18,562** 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.
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? **N/A** 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. $ **3,367**

(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. $ **3,915**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **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 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.