

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

<p>I. IDPH License ID Number: <u>0047472</u></p> <p>Facility Name: <u>Fondulac Rehab & Hlth Care C</u></p> <p>Address: <u>901 Illini Drive</u> <u>East Peoria</u> <u>61611</u> Number City Zip Code</p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: <u>(309) 694-6446</u> Fax # <u>(309) 694-4425</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/01/05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2013</u> to <u>12/31/2013</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Fondulac Rehab & Hlth Care C

0047472 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	19,627	1,345	2,489	23,461	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,627	1,345	2,489	23,461	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.59%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 98 and days of care provided 2,029

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	190,053	10,865	959	201,877		201,877	4,623	206,500		1
2	Food Purchase		141,982		141,982		141,982	(2,259)	139,723		2
3	Housekeeping	147,270	38,644		185,914		185,914	46	185,960		3
4	Laundry		15,864		15,864		15,864		15,864		4
5	Heat and Other Utilities			86,837	86,837		86,837	351	87,188		5
6	Maintenance	27,260	9,690	32,958	69,908		69,908	2,265	72,173		6
7	Other (specify):* Home Off. Ben. All.							261	261		7
8	TOTAL General Services	364,583	217,045	120,754	702,382		702,382	5,287	707,669		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	1,045,065	107,601	45,489	1,198,155		1,198,155	16	1,198,171		10
10a	Therapy		18	325,341	325,359		325,359		325,359		10a
11	Activities	45,572	35	1,663	47,270		47,270	(4,642)	42,628		11
12	Social Services	40,027			40,027		40,027		40,027		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,130,664	107,654	383,493	1,621,811		1,621,811	(4,626)	1,617,185		16
	C. General Administration										
17	Administrative			339,000	339,000		339,000	(268,118)	70,882		17
18	Directors Fees										18
19	Professional Services			11,899	11,899		11,899	122,685	134,584		19
20	Dues, Fees, Subscriptions & Promotions			4,699	4,699		4,699	1,075	5,774		20
21	Clerical & General Office Expenses	28,366	2,708	138,296	169,370		169,370	60,828	230,198		21
22	Employee Benefits & Payroll Taxes			244,030	244,030		244,030	(27)	244,003		22
23	Inservice Training & Education			250	250		250	92	342		23
24	Travel and Seminar							5	5		24
25	Other Admin. Staff Transportation			12,016	12,016		12,016	4,280	16,296		25
26	Insurance-Prop.Liab.Malpractice			35,905	35,905		35,905	827	36,732		26
27	Other (specify):* Home Off. Ben. All.							5,303	5,303		27
28	TOTAL General Administration	28,366	2,708	786,095	817,169		817,169	(73,050)	744,119		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,523,613	327,407	1,290,342	3,141,362		3,141,362	(72,389)	3,068,973		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 Rehab & Hlth Care C

#0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,379	114,379		114,379	4,415	118,794			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,490	83,490		83,490	29,495	112,985			32
33	Real Estate Taxes			43,816	43,816		43,816	372	44,188			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,720	28,720		28,720	684	29,404			35
36	Other (specify):*											36
37	TOTAL Ownership			270,405	270,405		270,405	34,966	305,371			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,863		101,863		101,863		101,863			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,036	182,036		182,036		182,036			42
43	Other (specify):* Non-allowable Costs		915	119,344	120,259		120,259	(120,259)				43
44	TOTAL Special Cost Centers		102,778	301,380	404,158		404,158	(120,259)	283,899			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,523,613	430,185	1,862,127	3,815,925		3,815,925	(157,682)	3,658,243			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: 1/1/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,358)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,932)	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	359	30		9
10	Interest and Other Investment Income	(17,620)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	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	(25,252)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,001)	43		24
25	Fund Raising, Advertising and Promotional	(2,797)	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	(17,127)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,900)		\$	30

BHF USE ONLY						
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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,782)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (11,782)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (157,682)		37

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

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

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

Fondulac Rehab & Hlth Care C

ID# 0047472

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (4,846)	43	1
2	X-Rays-Part A	(3,985)	43	2
3	Offset Transportation Revenue	(4,642)	11	3
4	Disallowed Pet Expense	(1,159)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(860)	21	5
6	Disallowed Special Events	(156)	43	6
7	Disallowed Chamber of Commerece Dues	(520)	20	7
8	Disallowed Travel Air	(959)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(17,127)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fondulac Rehab & Hlth Care C# 0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	4,623	0	0	0	0	0	0	0	0	0	4,623	1
2	Food Purchase	(2,358)	99	0	0	0	0	0	0	0	0	0	(2,259)	2
3	Housekeeping	0	46	0	0	0	0	0	0	0	0	0	46	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	351	0	0	0	0	0	0	0	0	0	351	5
6	Maintenance	0	2,265	0	0	0	0	0	0	0	0	0	2,265	6
7	Other (specify):*	0	261	0	0	0	0	0	0	0	0	0	261	7
8	TOTAL General Services	(2,358)	7,645	0	0	0	0	0	0	0	0	0	5,287	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	16	0	0	0	0	0	0	0	0	0	16	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,642)	0	0	0	0	0	0	0	0	0	0	(4,642)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,642)	16	0	0	0	0	0	0	0	0	0	(4,626)	16
	C. General Administration													
17	Administrative	0	(268,118)	0	0	0	0	0	0	0	0	0	(268,118)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,747	0	112,938	0	0	0	0	0	0	0	122,685	19
20	Fees, Subscriptions & Promotions	(520)	0	620	975	0	0	0	0	0	0	0	1,075	20
21	Clerical & General Office Expenses	(860)	0	57,294	4,394	0	0	0	0	0	0	0	60,828	21
22	Employee Benefits & Payroll Taxes	0	0	0	(27)	0	0	0	0	0	0	0	(27)	22
23	Inservice Training & Education	0	0	92	0	0	0	0	0	0	0	0	92	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	0	4,280	0	0	0	0	0	0	0	0	4,280	25
26	Insurance-Prop.Liab.Malpractice	0	0	827	0	0	0	0	0	0	0	0	827	26
27	Other (specify):*	0	0	5,303	0	0	0	0	0	0	0	0	5,303	27
28	TOTAL General Administration	(1,380)	(258,371)	68,421	118,280	0	0	0	0	0	0	0	(73,050)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,380)	(250,710)	68,421	118,280	0	0	0	0	0	0	0	(72,389)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fondulac Rehab & Hlth Care C# 0047472

Report Period Beginning:

1/1/2013 Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	359	0	3,798	258	0	0	0	0	0	0	0	4,415	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,620)	0	6,318	40,797	0	0	0	0	0	0	0	29,495	32
33	Real Estate Taxes	0	0	372	0	0	0	0	0	0	0	0	372	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	684	0	0	0	0	0	0	0	0	684	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,261)	0	11,172	41,055	0	0	0	0	0	0	0	34,966	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(120,259)	0	0	0	0	0	0	0	0	0	0	(120,259)	43
44	TOTAL Special Cost Centers	(120,259)	0	0	0	0	0	0	0	0	0	0	(120,259)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(145,900)	(250,710)	79,593	159,335	0	0	0	0	0	0	0	(157,682)	45

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%	\$ 4,623	\$ 4,623	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	99	99	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	351	351	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,265	2,265	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	261	261	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	16	16	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	339,000	Petersen Health Care, Inc.	100.00%	70,882	(268,118)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	9,747	9,747	12
13	V							13
14	Total		\$ 339,000			\$ 88,290	\$ * (250,710)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 620	\$	620	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	57,294		57,294	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	92		92	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5		5	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,280		4,280	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	827		827	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,303		5,303	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,798		3,798	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,318		6,318	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	372		372	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%	684		684	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		\$			\$ 79,593	\$ *	79,593	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	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%	112,938	112,938	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	975	975	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	4,394	4,394	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(27)	(27)	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%	258	258	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	40,797	40,797	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		\$			\$ 159,335	\$ * 159,335	39

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

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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 Restaurants,	Peoria	Restaurant	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	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				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 & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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: 1/1/2013 Ending: 12/31/2013

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											3
4	N/A										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:

1/1/2013

Ending: 2/31/2013

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	1,560,986	75	\$ 307,592	\$ 295,212	23,461	\$ 4,623	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	23,461	99	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	23,461	46	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	23,461	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	23,461	351	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	23,461	2,265	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	23,461	261	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	23,461	16	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	23,461	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	23,461	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	23,461	70,882	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	23,461	9,747	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	23,461	620	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	23,461	57,294	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	23,461	92	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	23,461	5	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	23,461	4,280	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	23,461	827	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	23,461	5,303	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	23,461	3,798	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	23,461	6,318	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	23,461	372	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	23,461	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	23,461	684	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 167,883	25

Facility Name & ID Number Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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	408,598	21	\$	23,461	\$	1
2	2	Food	Resident Days	408,598	21		23,461		2
3	3	Housekeeping	Resident Days	408,598	21		23,461		3
4	4	Laundry	Resident Days	408,598	21		23,461		4
5	5	Utilities	Resident Days	408,598	21		23,461		5
6	6	Maintenance	Resident Days	408,598	21		23,461		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21		23,461		7
8	10	Nursing and Medical Records	Resident Days	408,598	21		23,461		8
9	12	Social Services	Resident Days	408,598	21		23,461		9
10	17	Administrative	Resident Days	408,598	21		23,461		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927	23,461	112,938	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972	23,461	975	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520	23,461	4,394	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)	23,461	(27)	14
15	23	Inservice Training & Education	Resident Days	408,598	21		23,461		15
16	24	Travel and Seminar	Resident Days	408,598	21		23,461		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21		23,461		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21		23,461		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21		23,461		19
20	30	Depreciation	Resident Days	408,598	21	4,500	23,461	258	20
21	32	Interest	Resident Days	408,598	21	710,525	23,461	40,797	21
22	33	Real Estate Taxes	Resident Days	408,598	21		23,461		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21		23,461		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21		23,461		24
25	TOTALS					\$ 2,774,979	\$	\$ 159,335	25

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 3,100,000	\$ 2,314,155	12/31/13	Varies	\$ 83,490					
2																
3																
4																
5																
Working Capital																
6																
7																
8																
9	TOTAL Facility Related						\$ 3,100,000	\$ 2,314,155			\$ 83,490					
B. Non-Facility Related*																
10																
11											(17,620)					
12											6,318					
13											40,797					
14	TOTAL Non-Facility Related						\$	\$			\$ 29,495					
15	TOTALS (line 9+line14)						\$ 3,100,000	\$ 2,314,155			\$ 112,985					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.				\$	<u>37,872</u> 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.)	2012			\$	<u>40,240</u> 2
3. Under or (over) accrual (line 2 minus line 1).				\$	<u>2,368</u> 3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<u>41,448</u> 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.)				\$	<u> </u> 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		<u>372</u>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<u>44,188</u> 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>35,261</u>	8		
	2009	<u>36,216</u>	9		
	2010	<u>37,082</u>	10		
	2011	<u>36,768</u>	11		
	2012	<u>40,240</u>	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2012	\$		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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fondulac Rehab & Hlth Care C 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 2012 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 2012.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>01-01-26-300-009</u>	<u>Long-Term Care Facility</u>	<u>\$ 40,240.18</u>	<u>\$ 40,240.18</u>
2.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
3.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
4.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
5.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
6.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
7.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
8.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
9.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
10.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
		TOTALS	<u>\$ 40,240.18</u>	<u>\$ 40,240.18</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,928 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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	TOTALS	225,205		\$ 123,750	3

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	\$ 736,015	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Original Land Improvements	2005		15,000		15	1,000	1,000	8,500	9
10	Sidewalks	2006		3,200		15	213	213	1,598	10
11	Fire Alarm system	2006		4,030		10	403	403	3,022	11
12	Replace water main	2006		4,600		25	184	184	1,380	12
13	Water heater replacement	2006		3,097		10	310	310	2,325	13
14	Cubicle Curtains	2007		5,193		20	260	260	1,638	14
15	Door Alarm	2007		1,697		15	113	113	791	15
16	Fire Alarm	2007		1,854		15	124	124	868	16
17	Blinds & Valances	2007		4,699		10	470	470	3,003	17
18	Wallpaper for 3 Halls & Front Lobby	2007		2,258		15	151	151	931	18
19	Painting for all rooms, office area, bathrooms, hallways	2007		13,436		15	896	896	5,768	19
20	Carpeting for Hallways	2007		6,541		15	436	436	2,782	20
21	Water heater replacement - labor	2008		1,813		7	260	260	1,430	21
22	Water Heater	2008		11,615		7	1,660	1,660	9,130	22
23	Parking lot resurfacing	2008		34,750		39	892	892	4,906	23
24	Generator Repair	2009		2,599		7	372	372	1,674	24
25	Compressor Repair	2009		2,971		7	424	424	1,908	25
26	Freezer Repair	2009		3,445		7	492	492	2,460	26
27	Landscaping	2010		4,850		15	324	324	1,134	27
28	Cabinetry-Nursing Stations	2010		14,218		15	948	948	3,318	28
29	Carpet and Tiling in Nursing Stations and Kitchen	2010		15,811		15	1,054	1,054	3,689	29
30	Water Softener	2011		2,974		7	424	424	848	30
31	Water Heater	2011		5,737		7	820	820	1,640	31
32	Water Heater	2011		2,989		7	428	428	856	32
33	Tile Replacement in Showers	2011		15,567		15	1,038	1,038	2,076	33
34	Roof Replacement on North Section	2011		49,142		25	1,966	1,966	4,915	34
35	Water Main Repair	2012		3,602		7	514	514	771	35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 781	\$ 781	\$ 781	37
38	Bathroom Fixtures	2013	2,809		7	201	201	201	38
39	Blacktopping	2013	10,500		7	750	750	750	39
40	Painting-Exterior	2013	11,071		15	369	369	369	40
41	Alarm System Panel Replacement	2013	4,273		7	305	305	305	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	Land Improvements Booked			2,428			(2,428)		63
64	Building Booked			86,320			(86,320)		64
65	Building Improvement Booked			14,123			(14,123)		65
66									66
67	2013-Home Office Allocation-Building Improvements		11,031			265	265		67
68	2013-Home Office Allocation-Land Improvements		1,030			66	66		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,454,084	\$ 102,871		\$ 105,503	\$ 2,632	\$ 811,782	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	\$ 91,207	\$ 10,494	\$ 9,119	\$ (1,375)	5-10 yrs.	\$ 47,018	71
72	Current Year Purchases	14,270	1,014	447	(567)	10 yrs.	713	72
73	Fully Depreciated Assets	416,240					416,240	73
74	Home Office Allocation			3,725	3,725			74
75	TOTALS	\$ 521,717	\$ 11,508	\$ 13,291	\$ 1,783		\$ 463,971	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)	\$ 3,099,551	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,379	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,794	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,415	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,275,753	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	N/A				87
88					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: 1/1/2013

Ending: 12/31/2013

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 22,466 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 Rehab & Hlth Care C
0047472**

Period Beginning 1/1/2013
Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 11,002
Dishwasher	713
Laundry Equipment	-
Copier	10,067
Home Office Allocation	684
	<u>22,466</u>

Facility Name & ID Number Fondulac Rehab & Hlth Care C # 0047472 Report Period Beginning: 1/1/2013 Ending: 12/31/2013
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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	7,802	\$ 117,032	\$	7,802	\$ 117,032	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,010	30,157		2,010	30,157	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		11,877	178,152	18	11,877	178,170	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				101,863		101,863	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	TOTAL			\$	21,689	\$ 325,341	\$ 101,881	21,689	\$ 427,222	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: **1/1/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,367,474	\$ 3,367,474	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>188,255</u>)	751,908	751,908	3
4	Supply Inventory (priced at)	16,862	16,862	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,345	34,345	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	1,688	1,688	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,172,277	\$ 4,172,277	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	2,175,781	14
15	Leasehold Improvements, at Historical Cost	203,307	278,303	15
16	Equipment, at Historical Cost	523,327	521,717	16
17	Accumulated Depreciation (book methods)	(1,265,266)	(1,275,753)	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)	\$ 1,807,668	\$ 1,823,798	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,979,945	\$ 5,996,075	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 903,959	\$ 903,959	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,051	47,051	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,161	6,161	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,448	41,448	32
33	Accrued Interest Payable	6,314	6,314	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	50,276	50,276	36
37	<u>Accrued Management Fees</u>	260,736	260,736	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,315,945	\$ 1,315,945	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,314,155	2,314,155	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Due to Due From</u>	1,647,548	1,647,548	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,961,703	\$ 3,961,703	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,277,648	\$ 5,277,648	46
47	TOTAL EQUITY(page 18, line 24)	\$ 702,297	\$ 718,427	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,979,945	\$ 5,996,075	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 796,004	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 796,003	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(93,706)	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)	\$ (93,706)	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)	\$ 702,297	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,369,812	1
2	Discounts and Allowances for all Levels	(362,257)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,007,555	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	508,567	6
7	Oxygen	1,369	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 509,936	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,358	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	160,973	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,522	19
20	Radiology and X-Ray	13,553	20
21	Other Medical Services	3,200	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 181,606	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,620	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,620	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	860	28
28a	Transportation Revenue	4,642	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,502	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,722,219	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	702,382	31
32	Health Care	1,621,811	32
33	General Administration	817,169	33
B. Capital Expense			
34	Ownership	270,405	34
C. Ancillary Expense			
35	Special Cost Centers	222,122	35
36	Provider Participation Fee	182,036	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,815,925	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,706)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,706)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,372,939	44
45	Private Pay - Net Inpatient Revenue	233,273	45
46	Medicare - Net Inpatient Revenue	396,443	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	4,900	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,007,555	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 1/1/2013

Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 59,672	\$ 28.69	1
2	Assistant Director of Nursing	2,042	2,084	56,175	26.96	2
3	Registered Nurses	4,147	4,165	131,932	31.68	3
4	Licensed Practical Nurses	16,074	16,460	305,554	18.56	4
5	CNAs & Orderlies	40,418	41,528	456,413	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,939	1,952	25,936	13.29	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	40,027	19.24	11
12	Dietician					12
13	Food Service Supervisor	1,993	1,993	37,209	18.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,945	13,833	152,844	11.05	15
16	Dishwashers					16
17	Maintenance Workers	1,699	1,721	27,260	15.84	17
18	Housekeepers	15,972	16,665	147,270	8.84	18
19	Laundry					19
20	Administrator	2,080	2,080	70,882	34.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,003	2,003	28,366	14.16	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	132	132	1,466	11.11	31
32	Other Health C: CPC	1,742	1,790	33,853	18.91	32
33	Other(specify) <u>Transportation</u>	1,767	1,883	19,636	10.43	33
34	TOTAL (lines 1 - 33)	109,113	112,449	\$ 1,594,495 *	\$ 14.18	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	19	\$ 959	L1, C3	35
36	Medical Director	Monthly	11,000	L9, C3	36
37	Medical Records Consultant	Rev. of 2012 Inv.	(75)	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,685	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	110	L10, C3	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)	21	\$ 16,679		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,068	\$ 29,737	L10, C3	50
51	Licensed Practical Nurses	461	9,945	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,529	\$ 39,682		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Doug Harridge	Administrator	0	\$ 58,155	Workers' Compensation Insurance	\$ 47,507	IDPH License Fee	\$ 1,990	
Roger Herman	Administrator	0	12,727	Unemployment Compensation Insurance	52,298	Advertising: Employee Recruitment	525	
				FICA Taxes	112,838	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	26,288	Patient Background Checks	131 1,314	
				Employee Meals		Miscellaneous Licenses & Permits	350	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	520	
				Employee Relations	5,099	Home Office Allocation	1,595	
				Home Office Allocation	(27)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,882	TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,774		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(520)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 339,000				Non-allowable advertising	
							()	
							Yellow page advertising	
							()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 339,000				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 6,763				Out-of-State Travel	\$
Tazewell County Circuit Clerk	Legal Services		259					
Comcast Cable	Computer Services		902					
Gail and Rice	Accounting		614	N/A			In-State Travel	
Peoria County Circuit Clerk	Legal Services		86					
Homkamp Krueger & Co.	Accounting Services		775				Seminar Expense	
Consolidated Land Survey	Surveying Fees		2,500				Home Office Allocation	5
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,899	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 5	

* Attach copy of IMRF notifications

**See instructions.

Fondulac Rehab & Hlth Care C
0047472
Period Beginning
Period End

1/1/2013
12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,899
Home Office Allocation		
SmithAmundsen	Legal	579
Cole, Schotz, Meisel	Legal	319
Black, Hedin, Ballard	Legal	29
Elias, Meginnes, Riffle & Seghetti	Legal	58
Miller, Hall, and Triggs	Legal	1219
Evapar	Legal	235
Ginoli & Company	Accountants	3354
E-Health Data Solutions	Computer Services	4172
Miscellaneous	Computer Services	94
Odessian LLC	Computer Services	45
CCH	Computer Services	13
Lexis-Nexis	Computer Services	5
Ipanema Solutions	Computer Services	12
Macquarie Technology Services	Computer Services	83
Advanced Answers on Demand	Computer Services	4290
TeamViewer	Computer Services	14
Stratus Networks	Computer Services	346
Kemper Technology	Computer Services	267
AT&T	Computer Services	5
Medifax	Computer Services	39
Vision Share/Ability Network	Computer Services	587
Barracuda	Computer Services	106
CIAN	Computer Services	141
Comcast	Computer Services	31
Emdeon	Computer Services	47

Marotta Gund Budd & Dzera	Other Prof Fees	104723
David Budde	Other Prof Fees	27
Pharmacy Price Mangement	Other Prof Fees	540
All Scripts	Other Prof Fees	962
Registered Agent Solutions	Other Prof Fees	45
Healthink	Other Prof Fees	298
Total (agree to Schedule V, line 19, column 8)		<u>134,584</u>

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	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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. _____
- (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. \$ 25,571 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. \$ 182,036
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,358
- (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. \$ 4,642
- 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.