

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 East Peoria 61611

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

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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 1/1/2011 to 12/31/2011 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)

(Type or Print Name) Mark B. Petersen

(Title) Chief Executive Officer

Paid Preparer

(Signed)

(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

#	0047472	Report Period Beginning:	1/1/2011	Ending:	12/31/2011
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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)**

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 98 and days of care provided 1,754

Medicare Intermediary National Government Services

MODIFIED

ACCRUAL	X	CASH*		CASH*	
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

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

	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	23,499	2,750	2,024	28,273	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,499	2,750	2,024	28,273	14

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	188,856	13,272		202,128		202,128	5,704	207,832			1
2	Food Purchase		157,113		157,113		157,113	(3,494)	153,619			2
3	Housekeeping	156,347	31,913		188,260		188,260	37	188,297			3
4	Laundry		18,200		18,200		18,200		18,200			4
5	Heat and Other Utilities			106,272	106,272		106,272	373	106,645			5
6	Maintenance	40,946	14,798	27,375	83,119		83,119	2,326	85,445			6
7	Other (specify):* Home Off. Ben. All.							1,300	1,300			7
8	TOTAL General Services	386,149	235,296	133,647	755,092		755,092	6,246	761,338			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,247,205	143,060	11,465	1,401,730		1,401,730	57	1,401,787			10
10a	Therapy			299,900	299,900		299,900		299,900			10a
11	Activities	41,920	1,091	45	43,056		43,056	(20,109)	22,947			11
12	Social Services	37,866			37,866		37,866		37,866			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,326,991	144,151	317,410	1,788,552		1,788,552	(20,052)	1,768,500			16
	C. General Administration											
17	Administrative			396,200	396,200		396,200	(343,816)	52,384			17
18	Directors Fees											18
19	Professional Services			5,418	5,418		5,418	7,868	13,286			19
20	Dues, Fees, Subscriptions & Promotions			7,458	7,458		7,458	459	7,917			20
21	Clerical & General Office Expenses	28,036	4,062	9,226	41,324		41,324	54,679	96,003			21
22	Employee Benefits & Payroll Taxes			421,557	421,557		421,557		421,557			22
23	Inservice Training & Education							190	190			23
24	Travel and Seminar							56	56			24
25	Other Admin. Staff Transportation			12,555	12,555		12,555	4,886	17,441			25
26	Insurance-Prop.Liab.Malpractice			32,354	32,354		32,354	1,323	33,677			26
27	Other (specify):* Home Off. Ben. All.							21,612	21,612			27
28	TOTAL General Administration	28,036	4,062	884,768	916,866		916,866	(252,743)	664,123			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,741,176	383,509	1,335,825	3,460,510		3,460,510	(266,549)	3,193,961			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			168,429	168,429		168,429	6,575	175,004			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,913	155,913		155,913	62,329	218,242			32
33	Real Estate Taxes			37,962	37,962		37,962	470	38,432			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,223	60,223		60,223	833	61,056			35
36	Other (specify):*											36
37	TOTAL Ownership			422,527	422,527		422,527	70,207	492,734			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,225		71,225		71,225		71,225			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 Costs		624	70,492	71,116		71,116	(71,116)				43
44	TOTAL Special Cost Centers		71,849	124,147	195,996		195,996	(71,116)	124,880			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,741,176	455,358	1,882,499	4,079,033		4,079,033	(267,458)	3,811,575			45

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

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

	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	(3,520)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,298)	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	(1,295)	30		9
10	Interest and Other Investment Income	(64)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(219)	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	(2,206)	43		18
19	Entertainment				19
20	Contributions	(250)	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	(54,501)	43		24
25	Fund Raising, Advertising and Promotional	(4,862)	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 <u>See Page 5A</u>	(25,188)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,403)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 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)	(171,055)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (171,055)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (267,458)		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	<u>Gift and Coffee Shops</u>		X			40
41	<u>Barber and Beauty Shops</u>		X			41
42	<u>Laboratory and Radiology</u>		X			42
43	<u>Prescription Drugs</u>		X			43
44						44
45	<u>Other-Attach Schedule</u>		X			45
46	<u>Other-Attach Schedule</u>		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,099)	43	1
2	X-Rays-Part A	346	43	2
3	Offset Transportation Revenue	(20,109)	11	3
4	Disallowed Pet Expense	(857)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(299)	21	5
6	Disallowed Special Events	(1,170)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(25,188)		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,704	\$ 5,704	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	26	26	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	373	373	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,326	2,326	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,300	1,300	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	57	57	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	396,200	Petersen Health Care, Inc.	100.00%	52,384	(343,816)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,525	6,525	12
13	V								13
14	Total			\$ 396,200			\$ 68,732	\$ * (327,468)	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%	\$ 459	\$ 459	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	53,172	53,172	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	190	190	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	56	56	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,886	4,886	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,323	1,323	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	21,612	21,612	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	7,640	7,640	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	9,196	9,196	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	470	470	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%	833	833	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			\$			\$ 99,837	\$ * 99,837	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%	1,343	1,343	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,806	1,806	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	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%	230	230	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	53,197	53,197	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			\$			\$ 56,576	\$ * 56,576	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:

1/1/2011

Ending:

12/31/2011

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, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	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 System	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 I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care X	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	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 Ca	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 Rehabilitation & Health Care Center

0047472

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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 Rehabilitation & Health Care Center

0047472

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

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								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

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 Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	1,542,131	77	\$ 311,109	\$ 308,619	28,273	\$ 5,704	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	28,273	26	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	28,273	37	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	28,273	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	28,273	373	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	28,273	2,326	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	28,273	1,300	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	28,273	57	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	28,273	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	28,273	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	28,273	52,384	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	28,273	6,525	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	28,273	459	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	28,273	53,172	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	28,273	190	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	28,273	56	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	28,273	4,886	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	28,273	1,323	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	28,273	21,612	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	28,273	7,640	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	28,273	9,196	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	28,273	470	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	28,273	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	28,273	833	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 168,569	25

Facility Name & ID Number Fondulac Rehabilitation & Health Care Center # 0047472 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	402,040	21	\$	\$	28,273	\$	1
2	2	Food	Resident Days	402,040	21			28,273		2
3	3	Housekeeping	Resident Days	402,040	21			28,273		3
4	4	Laundry	Resident Days	402,040	21			28,273		4
5	5	Utilities	Resident Days	402,040	21			28,273		5
6	6	Maintenance	Resident Days	402,040	21			28,273		6
7	7	Mgmt. Allocation of Benefits	Resident Days	402,040	21			28,273		7
8	10	Nursing and Medical Records	Resident Days	402,040	21			28,273		8
9	12	Social Services	Resident Days	402,040	21			28,273		9
10	17	Administrative	Resident Days	402,040	21			28,273		10
11	19	Professional Services	Resident Days	402,040	21	19,096		28,273	1,343	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	402,040	21			28,273		12
13	21	Clerical and General Office	Resident Days	402,040	21	25,677		28,273	1,806	13
14	22	Employee Benefits & Payroll	Resident Days	402,040	21			28,273		14
15	23	Inservice Training & Education	Resident Days	402,040	21			28,273		15
16	24	Travel and Seminar	Resident Days	402,040	21			28,273		16
17	25	Other Admin. Staff Transport.	Resident Days	402,040	21			28,273		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	402,040	21			28,273		18
19	27	Mgmt. Allocation of Benefits	Resident Days	402,040	21			28,273		19
20	30	Depreciation	Resident Days	402,040	21	3,263		28,273	230	20
21	32	Interest	Resident Days	402,040	21	756,464		28,273	53,197	21
22	33	Real Estate Taxes	Resident Days	402,040	21			28,273		22
23	34	Rent-Facility and Grounds	Resident Days	402,040	21			28,273		23
24	35	Rent-Equipment & Vehicles	Resident Days	402,040	21			28,273		24
25	TOTALS					\$ 804,500	\$		\$ 56,576	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	\$ 2,935,318	12/31/13	Varies	\$ 155,913	1
2												2
3								Interest Income Offset			(64)	3
4								Home Office Allocation-PHC			9,196	4
5								Home Office Allocation-PHO			53,197	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,100,000	\$ 2,935,318			\$ 218,242	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	\$ 2,935,318			\$ 218,242	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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	37,320	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.)		2010		\$	37,082	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(238)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	38,200	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.)					470	
				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	38,432	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	33,455	8		
		2007	32,871	9		
		2008	35,261	10		
		2009	36,216	11		
		2010	37,082	12		
Accrual based on prior year tax bill.						

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

2010 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 2010 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 2010.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 01-01-26-300-009	Long-Term Care Facility	\$ 37,082.12	\$ 37,082.12
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 37,082.12	\$ 37,082.12

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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	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:

1/1/2011

Ending:

12/31/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 562,835	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	6,500	9
10	Sidewalks			2006	3,200		15	213	213	1,172	10
11	Fire Alarm system			2006	4,030		10	403	403	2,216	11
12	Replace water main			2006	4,600		25	184	184	1,012	12
13	Water heater replacement			2006	3,097		10	310	310	1,705	13
14	Cubicle Curtains			2007	5,193		20	260	260	1,118	14
15	Door Alarm			2007	1,697		15	113	113	565	15
16	Fire Alarm			2007	1,854		15	124	124	620	16
17	Blinds & Valances			2007	4,699		10	470	470	2,063	17
18	Wallpaper for 3 Halls & Front Lobby			2007	2,258		15	151	151	629	18
19	Painting for all rooms, office area, bathrooms, hallways			2007	13,436		15	896	896	3,976	19
20	Carpeting for Hallways			2007	6,541		15	436	436	1,910	20
21	Water heater replacement - labor			2008	1,813		7	260	260	910	21
22	Water Heater			2008	11,615		7	1,660	1,660	5,810	22
23	Parking lot resurfacing			2008	34,750		39	892	892	3,122	23
24	Generator Repair			2009	2,599		7	372	372	930	24
25	Compressor Repair			2009	2,971		7	424	424	1,060	25
26	Freezer Repair			2009	3,445		7	492	492	1,476	26
27	Landscaping			2010	4,850		15	324	324	486	27
28	Cabinetry-Nursing Stations			2010	14,218		15	948	948	1,422	28
29	Carpet and Tiling in Nursing Stations and Kitchen			2010	15,811		15	1,054	1,054	1,581	29
30	Water Softener			2011	2,974		7	212	212	212	30
31	Water Heater			2011	5,737		7	410	410	410	31
32	Water Heater			2011	2,989		7	214	214	214	32
33	Tile Replacement in Showers			2011	15,567		15	519	519	519	33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	Land Improvements Booked			2,428			(2,428)		57
58	Building Booked			86,320			(86,320)		58
59	Building Improvement Booked			10,154			(10,154)		59
60									60
61									61
62									62
63	2011-Home Office Allocation-Building & Improvements		13,457			323	323		63
64	2011-Home Office Allocation-Land Improvements		1,256			80	80		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,364,407	\$ 98,902		\$ 99,334	\$ 432	\$ 604,473	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	\$ 499,849	\$ 68,744	\$ 67,825	\$ (919)	10 yrs.	\$ 417,544	71
72	Current Year Purchases	7,567	783	378	(405)	10 yrs.	378	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			7,467	7,467			74
75	TOTALS	\$ 507,416	\$ 69,527	\$ 75,670	\$ 6,143		\$ 417,922	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,995,573	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 168,429	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,004	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,575	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,022,395	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$54,118
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	\$578.17	\$6,938	17
18					18
19					19
20					20
21	TOTAL		\$578.17	\$6,938	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent

12. /2012\$

13. /2013\$

14. /2014\$

* 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 1/1/2011
Period End 12/31/2011

Schedule 14A

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

Medical Equipment	\$	44,806
Dishwasher		708
Laundry Equipment		-
Copier		7,771
Home Office Allocation		833
		54,118

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

☒ 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		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	\$	7,255	\$ 108,832	\$	7,255	\$ 108,832	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,919	43,789		2,919	43,789	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,767	146,509		9,767	146,509	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 prescripts				71,225		71,225	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			51	770		51	770	13
14	TOTAL			\$	19,992	\$ 299,900	\$ 71,225	19,992	\$ 371,125	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.

This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,216,963	\$ 1,216,963	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,000)	1,310,939	1,310,939	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,312	27,312	6
7	Other Prepaid Expenses	16,862	16,862	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,572,076	\$ 2,572,076	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	2,178,207	14
15	Leasehold Improvements, at Historical Cost	162,928	186,200	15
16	Equipment, at Historical Cost	509,057	507,416	16
17	Accumulated Depreciation (book methods)	(995,851)	(1,022,395)	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)	\$ 2,022,434	\$ 1,973,178	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,594,510	\$ 4,545,254	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 785,459	\$ 785,459	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,892	38,892	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,406	5,406	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,200	38,200	32
33	Accrued Interest Payable	15,368	15,368	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	34,944	34,944	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 918,269	\$ 918,269	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,935,318	2,935,318	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)	\$ 2,935,318	\$ 2,935,318	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,853,587	\$ 3,853,587	46
47	TOTAL EQUITY(page 18, line 24)	\$ 740,923	\$ 691,667	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,594,510	\$ 4,545,254	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 792,961	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(20,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 772,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,038)	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)	\$ (32,038)	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)	\$ 740,923	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Fondulac Rehabilitation & Health Care Center**# **0047472**Report Period Beginning: **1/1/2011**Ending: **12/31/2011**

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,641,707	1
2	Discounts and Allowances for all Levels	(187,515)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,454,192	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	416,500	6
7	Oxygen	2,354	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 418,854	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	3,520	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	137,824	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	902	19
20	Radiology and X-Ray	6,926	20
21	Other Medical Services	4,305	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 153,477	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	64	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	299	28
28a	Transportation Revenue	20,109	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,408	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,046,995	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	755,092	31
32	Health Care	1,788,552	32
33	General Administration	916,866	33
	B. Capital Expense		
34	Ownership	422,527	34
	C. Ancillary Expense		
35	Special Cost Centers	142,341	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)*	\$ 4,079,033	40
41	Income before Income Taxes (line 30 minus line 40)**	(32,038)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (32,038)	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.

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	1,892	1,892	\$ 56,115	\$ 29.66	1
2	Assistant Director of Nursing	1,681	1,845	48,702	26.40	2
3	Registered Nurses	6,995	7,240	183,434	25.34	3
4	Licensed Practical Nurses	16,266	16,995	365,395	21.50	4
5	CNAs & Orderlies	45,248	47,033	536,417	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,776	1,776	19,539	11.00	9
10	Activity Assistants	108	108	1,083	10.03	10
11	Social Service Workers	2,080	2,080	37,866	18.20	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,529	17.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,252	15,005	153,327	10.22	15
16	Dishwashers					16
17	Maintenance Workers	3,055	3,144	40,946	13.02	17
18	Housekeepers	17,184	17,494	156,347	8.94	18
19	Laundry					19
20	Administrator	558	558	19,300	34.59	20
21	Assistant Administrator	1,144	1,144	33,084	28.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,947	2,117	28,036	13.24	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	1,027	1,027	10,462	10.19	31
32	Other Health Care Care Plan Coord	1,907	1,907	46,680	24.48	32
33	Other(specify) Transportation	2,077	2,077	21,298	10.25	33
34	TOTAL (lines 1 - 33)	121,277	125,522	\$ 1,793,560 *	\$ 14.29	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	L9, C3	36
37	Medical Records Consultant	4	75	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,093	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	\$ 11,168		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	172	\$ 5,525	L10, C3	50
51	Licensed Practical Nurses	9	256	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	181	\$ 5,781		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Robert Wilson	Administrator	0	\$ 6,300
Lance Tossell	Assistant Adm.	0	33,084
Renee Gass	Administrator	0	13,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 52,384
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 396,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 396,200
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 3,485
AT&T	Computer Services		200
Tazewell County Circuit Clerk	Legal Services		26
Comcast Cable	Computer Services		800
HonKamp Krueger	Accounting		907
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,418
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 29,694
Unemployment Compensation Insurance			40,040
FICA Taxes			130,888
Employee Health Insurance			219,726
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			376
Employee Retirement			452
Life Insurance			381
TOTAL (agree to Schedule V, line 22, col.8)			\$ 421,557
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			\$ 3,980
Advertising: Employee Recruitment			499
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	229		2,296
Miscellaneous Licenses & Permits			583
Miscellaneous Dues & Subscriptions			100
Home Office Allocation			459
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,917
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			56
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 56

*** Attach copy of IMRF notifications**

****See instructions.**

Fondulac Rehabilitation & Health Care Center
0047472

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,418
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	7
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	2,249
Miscellaneous Vendors	Computer Services	73
Advanced Answers on Demand	Computer Services	3,785
Access 2 Go	Computer Services	372
Kemper Technology	Computer Services	173
MediFax	Computer Services	59
VisionShare	Computer Services	266
Advanced System Design	Computer Services	349
Simple LTC	Computer Services	438
Optimizer Systems	Other Prof Fees	44
Clifton Gunderson	Other Prof Fees	15
Mike Miller	Other Prof Fees	21
OIC Group	Other Prof Fees	5
All Scripts	Other Prof Fees	11
Total (agree to Schedule V, line 19, column 8)		<u>13,286</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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
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? 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. \$ 22,289 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,520
- (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. \$ 409
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees