

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Rehab & Hlth Care C

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

County: Tazewell

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

HFS ID Number:

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

Type of Ownership:

☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☒	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 673-3009
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 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)	Mark B. Petersen		
	(Title)	Chief Executive Officer		
Paid Preparer	(Signed)		(Date)	
	(Print Name and Title)			
	(Firm Name & Address)			
	(Telephone)	()	Fax # ()	

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

#	0047472	Report Period Beginning:	1/1/2016	Ending:	12/31/2016
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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.)

N/A

None

Yes

YES ☒ NO ☐

YES ☐ NO ☒

Date started 10/1/2005

YES ☒ Date 10/1/2005 NO ☐

YES ☒ NO ☐ If YES, enter number

of beds certified	98	and days of care provided	2,035
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IV. ACCOUNTING BASIS

ACCRUAL ☒ X

CASH*

CASH* ☐

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

Tax Year: 12/31/2016 **Fiscal Year:** 12/31/2016

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

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,744	2,287	2,281	23,312	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,744	2,287	2,281	23,312	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.17%

Facility Name & ID Number **Fondulac Rehab & Hlth Care C** # **0047472** Report Period Beginning: **1/1/2016** Ending: **12/31/2016**
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	189,627	12,300		201,927		201,927	4,789	206,716			1
2	Food Purchase		150,345		150,345		150,345	(1,248)	149,097			2
3	Housekeeping	150,083	22,235		172,318		172,318	84	172,402			3
4	Laundry		12,690		12,690		12,690		12,690			4
5	Heat and Other Utilities			81,630	81,630		81,630	279	81,909			5
6	Maintenance	37,554	25,088	19,619	82,261		82,261	7,335	89,596			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	377,264	222,658	101,249	701,171		701,171	11,239	712,410			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,138,061	139,974	15,105	1,293,140		1,293,140	(1,205)	1,291,935			10
10a	Therapy		31	310,413	310,444		310,444		310,444			10a
11	Activities	60,714	361		61,075		61,075	(5,805)	55,270			11
12	Social Services	43,422			43,422		43,422		43,422			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,242,197	140,366	337,518	1,720,081		1,720,081	(7,010)	1,713,071			16
	C. General Administration											
17	Administrative			287,700	287,700		287,700	(218,325)	69,375			17
18	Directors Fees											18
19	Professional Services			(4,901)	(4,901)		(4,901)	31,415	26,514			19
20	Dues, Fees, Subscriptions & Promotions			11,738	11,738		11,738	510	12,248			20
21	Clerical & General Office Expenses	30,866	2,766	13,083	46,715		46,715	58,734	105,449			21
22	Employee Benefits & Payroll Taxes			201,087	201,087		201,087	31,214	232,301			22
23	Inservice Training & Education							107	107			23
24	Travel and Seminar							52	52			24
25	Other Admin. Staff Transportation			7,828	7,828		7,828	4,392	12,220			25
26	Insurance-Prop.Liab.Malpractice			24,134	24,134		24,134	22,952	47,086			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	30,866	2,766	540,669	574,301		574,301	(68,949)	505,352			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,650,327	365,790	979,436	2,995,553		2,995,553	(64,720)	2,930,833			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			2,436	2,436		2,436	138,567	141,003			30
31	Amortization of Pre-Op. & Org.							11,408	11,408			31
32	Interest							120,442	120,442			32
33	Real Estate Taxes							41,523	41,523			33
34	Rent-Facility & Grounds			310,248	310,248		310,248	(310,248)				34
35	Rent-Equipment & Vehicles			40,466	40,466		40,466	1,004	41,470			35
36	Other (specify):*											36
37	TOTAL Ownership			353,150	353,150		353,150	2,696	355,846			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,267		56,267		56,267		56,267			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,436	181,436		181,436		181,436			42
43	Other (specify):*	39,659	728	95,174	135,561		135,561	(135,561)				43
44	TOTAL Special Cost Centers	39,659	56,995	276,610	373,264		373,264	(135,561)	237,703			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,689,986	422,785	1,609,196	3,721,967		3,721,967	(197,585)	3,524,382			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	(1,335)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,126)	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	5,673	30		9
10	Interest and Other Investment Income	(753)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(97)	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	(15,021)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,000)	43		24
25	Fund Raising, Advertising and Promotional	(45,604)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(19,968)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (139,231)		\$	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 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)	(58,354)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (58,354)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (197,585)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,128)	43	1
2	X-Rays-Part A	(4,391)	43	2
3	Offset Transportation Revenue	(5,805)	11	3
4	Disallowed Pet Expense		43	4
5	Offset Miscellaneous Office Supplies Revenue	(103)	21	5
6	Disallowed Special Events	(194)	43	6
7	Disallowed Chamber of Commerce Dues		20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(1,347)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,968)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	4,789	0	0	0	0	0	0	0	0	0	4,789	1
2	Food Purchase	(1,335)	87	0	0	0	0	0	0	0	0	0	(1,248)	2
3	Housekeeping	0	84	0	0	0	0	0	0	0	0	0	84	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	279	0	0	0	0	0	0	0	0	0	279	5
6	Maintenance	0	2,614	0	0	952	0	0	0	0	0	0	3,566	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,335)	7,853	0	0	952	0	0	0	0	0	0	7,470	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	(1,347)	142	0	0	0	0	0	0	0	0	0	(1,205)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,805)	0	0	0	0	0	0	0	0	0	0	(5,805)	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	(7,152)	142	0	0	0	0	0	0	0	0	0	(7,010)	16
	C. General Administration													
17	Administrative	0	(218,325)	0	0	0	0	0	0	0	0	0	(218,325)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,194	0	12,901	6,320	0	0	0	0	0	0	31,415	19
20	Fees, Subscriptions & Promotions	0	0	510	0	0	0	0	0	0	0	0	510	20
21	Clerical & General Office Expenses	(103)	0	55,824	0	6,782	0	0	0	0	0	0	62,503	21
22	Employee Benefits & Payroll Taxes	0	0	31,214	0	0	0	0	0	0	0	0	31,214	22
23	Inservice Training & Education	0	0	107	0	0	0	0	0	0	0	0	107	23
24	Travel and Seminar	0	0	52	0	0	0	0	0	0	0	0	52	24
25	Other Admin. Staff Transportation	0	0	4,392	0	0	0	0	0	0	0	0	4,392	25
26	Insurance-Prop.Liab.Malpractice	0	0	619	0	22,333	0	0	0	0	0	0	22,952	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(103)	(206,131)	92,718	12,901	35,435	0	0	0	0	0	0	(65,180)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,590)	(198,136)	92,718	12,901	36,387	0	0	0	0	0	0	(64,720)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fondulac Rehab & Hlth Care C # 0047472 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,673	0	12,353	1,558	118,983	0	0	0	0	0	0	138,567	30
31	Amortization of Pre-Op. & Org.	0	0	0	2,855	8,553	0	0	0	0	0	0	11,408	31
32	Interest	(753)	0	363	19,440	101,392	0	0	0	0	0	0	120,442	32
33	Real Estate Taxes	0	0	284	0	41,239	0	0	0	0	0	0	41,523	33
34	Rent-Facility & Grounds	0	0	0	0	(310,248)	0	0	0	0	0	0	(310,248)	34
35	Rent-Equipment & Vehicles	0	0	1,004	0	0	0	0	0	0	0	0	1,004	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,920	0	14,004	23,853	(40,081)	0	0	0	0	0	0	2,696	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):*	(135,561)	0	0	0	0	0	0	0	0	0	0	(135,561)	43
44	TOTAL Special Cost Centers	(135,561)	0	0	0	0	0	0	0	0	0	0	(135,561)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(139,231)	(198,136)	106,722	36,754	(3,694)	0	0	0	0	0	0	(197,585)	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		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 Management, Inc.	100.00%	\$ 4,789	\$ 4,789	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	87	87	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	84	84	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	279	279	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,614	2,614	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	142	142	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	287,700	Petersen Health Care Management, Inc.	100.00%	69,375	(218,325)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	12,194	12,194	12
13	V								13
14	Total			\$ 287,700			\$ 89,564	\$ * (198,136)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	<u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>\$ 510</u>	<u>\$ 510</u>	15
16	V	21	<u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>55,824</u>	<u>55,824</u>	16
17	V	22	<u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>31,214</u>	<u>31,214</u>	17
18	V	23	<u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>107</u>	<u>107</u>	18
19	V	24	<u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>52</u>	<u>52</u>	19
20	V	25	<u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>4,392</u>	<u>4,392</u>	20
21	V	26	<u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>619</u>	<u>619</u>	21
22	V	27	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		22
23	V	30	<u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>12,353</u>	<u>12,353</u>	23
24	V	32	<u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>363</u>	<u>363</u>	24
25	V	33	<u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>284</u>	<u>284</u>	25
26	V	35	<u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>1,004</u>	<u>1,004</u>	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			\$			\$ 106,722	\$ * 106,722	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	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	12,901	12,901	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%	0		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	30	Depreciation		Petersen Health Operations, LLC	100.00%	1,558	1,558	33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	2,855	2,855	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	19,440	19,440	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			\$			\$ 36,754	\$ * 36,754	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	6	Mainteance	\$	Fondulac Land, LLC	100.00%	\$ 952	\$ 952	15
16	V	19	Professional Services	\$	Fondulac Land, LLC	100.00%	\$ 6,320	6,320	16
17	V	21	Equipment		Fondulac Land, LLC	100.00%	6,782	6,782	17
18	V	26	Insurance-Property		Fondulac Land, LLC	100.00%	5,069	5,069	18
19	V	26	Insurance-Mortgage Insurance		Fondulac Land, LLC	100.00%	17,264	17,264	19
20	V	30	Depreciation		Fondulac Land, LLC	100.00%	118,983	118,983	20
21	V	31	Amortization		Fondulac Land, LLC	100.00%	8,553	8,553	21
22	V	32	Interest	870	Fondulac Land, LLC	100.00%	102,262	101,392	22
23	V	33	Real Estate Taxes		Fondulac Land, LLC	100.00%	41,239	41,239	23
24	V	34	Rent-Income and Grounds	310,248	Fondulac Land, LLC	100.00%		(310,248)	24
25	V						0		25
26	V						0		26
27	V						0		27
28	V						0		28
29	V						0		29
30	V						0		30
31	V						0		31
32	V						0		32
33	V						0		33
34	V						0		34
35	V						0		35
36	V						0		36
37	V						0		37
38	V						0		38
39	Total			\$ 311,118			\$ 307,424	\$ * (3,694)	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:

1/1/2016

Ending:

12/31/2016

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 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 Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	23,312	\$ 4,789	1
2	2	Food	Resident Days	75	5,673	0	23,312	87	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	23,312	84	3
4	5	Utilities	Resident Days	75	18,209	0	23,312	279	4
5	6	Maintenance	Resident Days	75	170,632	137,057	23,312	2,614	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	23,312	0	6
7	9	Medical Director	Resident Days	75	0	0	23,312	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	23,312	142	8
9	10A	Therapy	Resident Days	75	0	0	23,312	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	23,312	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	23,312	69,375	11
12	19	Professional Services	Resident Days	75	795,918	0	23,312	12,194	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	23,312	510	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	23,312	55,824	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	23,312	31,214	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	23,312	107	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	23,312	52	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	23,312	4,392	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	23,312	619	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	23,312	0	20
21	30	Depreciation	Resident Days	75	806,271	0	23,312	12,353	21
22	32	Interest	Resident Days	75	23,686	0	23,312	363	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	23,312	284	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	23,312	1,004	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 196,286	25

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

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	197,666	9	\$	\$	23,312	\$	1
2	2	Food	Resident Days	197,666	9			23,312		2
3	3	Housekeeping	Resident Days	197,666	9			23,312		3
4	4	Laundry	Resident Days	197,666	9			23,312		4
5	5	Utilities	Resident Days	197,666	9			23,312		5
6	6	Maintenance	Resident Days	197,666	9			23,312		6
7	7	Mgmt. Allocation of Benefits	Resident Days	197,666	9			23,312		7
8	10	Nursing and Medical Records	Resident Days	197,666	9			23,312		8
9	15	Mgmt. Allocation of Benefits	Resident Days	197,666	9			23,312		9
10	17	Administrative	Resident Days	197,666	9			23,312		10
11	19	Professional Services	Resident Days	197,666	9	109,392		23,312	12,901	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	197,666	9			23,312		12
13	21	Clerical and General Office	Resident Days	197,666	9			23,312		13
14	22	Employee Benefits & Payroll	Resident Days	197,666	9			23,312		14
15	23	Inservice Training & Education	Resident Days	197,666	9			23,312		15
16	24	Travel and Seminar	Resident Days	197,666	9			23,312		16
17	25	Other Admin. Staff Transport.	Resident Days	197,666	9			23,312		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	197,666	9			23,312		18
19	30	Depreciation	Resident Days	197,666	9	13,207		23,312	1,558	19
20	31	Amortization	Resident Days	197,666	9	24,205		23,312	2,855	20
21	32	Interest	Resident Days	197,666	9	164,836		23,312	19,440	21
22	33	Real Estate Taxes	Resident Days	197,666	9			23,312		22
23	34	Rent-Facility and Grounds	Resident Days	197,666	9			23,312		23
24	35	Rent-Equipment & Vehicles	Resident Days	197,666	9			23,312		24
25	TOTALS					\$ 311,640	\$		\$ 36,754	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	Capital Finance Group		X	Mortgage	Varies	9/15/14	\$ 2,799,200	\$ 2,616,340	12/31/34	Varies	\$ 102,262	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,799,200	\$ 2,616,340			\$ 102,262	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(1,623)	10	
11								Home Office Allocation-PHO			19,440	11	
12								Home Office Allocation-PHCM			363	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 18,180	14	
15	TOTALS (line 9+line14)						\$ 2,799,200	\$ 2,616,340			\$ 120,442	15	

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

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

B. Real Estate Taxes

[illegible]

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.

FACILITY NAME	Fondulac Rehab & Hlth Care C	COUNTY	Tazewell
---------------	------------------------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

IL478-2471

A. Square Feet: 24,928

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: 188,175

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 11,408

4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	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 Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	\$ 995,785	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	11,500	9
10	Sidewalks			2006	3,200		15	213	213	2,237	10
11	Fire Alarm system			2006	4,030		10	202	202	4,030	11
12	Replace water main			2006	4,600		25	184	184	1,932	12
13	Water heater replacement			2006	3,097		10	152	152	3,097	13
14	Cubicle Curtains			2007	5,193		20	260	260	2,418	14
15	Door Alarm			2007	1,697		15	113	113	1,130	15
16	Fire Alarm			2007	1,854		15	124	124	1,240	16
17	Blinds & Valances			2007	4,699		10	470	470	4,413	17
18	Wallpaper for 3 Halls & Front Lobby			2007	2,258		15	151	151	1,384	18
19	Painting for all rooms, office area, bathrooms, hallways			2007	13,436		15	896	896	8,456	19
20	Carpeting for Hallways			2007	6,541		15	436	436	4,090	20
21	Water heater replacement - labor			2008	1,813		7			1,813	21
22	Water Heater			2008	11,615		7			11,615	22
23	Parking lot resurfacing			2008	34,750		39	892	892	7,582	23
24	Generator Repair			2009	2,599		7	181	181	2,599	24
25	Compressor Repair			2009	2,971		7	215	215	2,971	25
26	Freezer Repair			2009	3,445		7			3,445	26
27	Landscaping			2010	4,850		15	324	324	2,106	27
28	Cabinetry-Nursing Stations			2010	14,218		15	948	948	6,162	28
29	Carpet and Tiling in Nursing Stations and Kitchen			2010	15,811		15	1,054	1,054	2,750	29
30	Water Softener			2011	2,974		7	424	424	2,120	30
31	Water Heater			2011	5,737		7	820	820	4,100	31
32	Water Heater			2011	2,989		7	428	428	2,140	32
33	Tile Replacement in Showers			2011	15,567		15	1,038	1,038	5,190	33
34	Roof Replacement on North Section			2011	49,142		25	1,966	1,966	10,813	34
35	Water Main Repair			2012	3,602		7	514	514	2,313	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Line Repair	2013	\$ 10,932	\$	7	\$ 1,562	\$ 1,562	\$ 5,467	37
38	Bathroom Fixtures	2013	2,809		7	402	402	1,407	38
39	Blacktopping	2013	10,500		7	1,500	1,500	5,250	39
40	Painting-Exterior	2013	11,071		15	738	738	2,583	40
41	Alarm System Panel Replacement	2013	4,273		7	610	610	2,135	41
42	Tile Replacement in Hallways and Kitchen	2014	13,185		15	879	879	2,198	42
43	Landscaping Around Building	2014	21,897		15	1,460	1,460	3,650	43
44	Landscaping Around Building	2014	8,944		15	596	596	1,490	44
45	Copper Line Repair	2015	3,241		7	464	464	696	45
46	Nurses Station Replacement	2015	8,982		7	1,284	1,284	1,926	46
47	Plumbing Repairs	2015	9,170		7	1,310	1,310	1,965	47
48	Water Softener Replacement	2015	6,126		7	876	876	1,314	48
49	Dumpster Pads	2015	19,686		15	1,312	1,312	1,968	49
50	Air Conditioner	2016	6,250		15	208	208	208	50
51	Water Sprinkler System Repair	2016	11,448		7	818	818	818	51
52	Exterior Landscaping	2016	8,050		7	575	575	575	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			22,374			(22,374)		65
66									66
67	2016-Home Office Allocation-Building Improvements		10,292			247	247		67
68	2016-Home Office Allocation-Land Improvements		947			61	61		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,570,241	\$ 111,122		\$ 114,497	\$ 3,375	\$ 1,143,081	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	\$136,472	\$10,229	\$12,698	\$2,469	5-10 yrs.	\$84,022	71
72	Current Year Purchases	2,873	68	205	137	7 yrs.	205	72
73	Fully Depreciated Assets	416,240					416,240	73
74	Home Office Allocation			13,603	13,603			74
75	TOTALS	\$555,585	\$10,297	\$26,506	\$16,209		\$500,467	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	3,249,576
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	121,419
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	141,003
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	19,584
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,643,548

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
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: \$34,532
- 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	Ford 2012 E150	\$578.00	\$6,938	17
18					18
19					19
20					20
21	TOTAL		\$578.00	\$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 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 26,271
Dishwasher	704
Generator	30
Copier	6,523
Home Office Allocation	<u>1,004</u>
	<u><u>34,532</u></u>

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

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(2), 10A(3)	hrs	\$	9,289	\$ 139,340	\$ 31	9,289	\$ 139,371	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,095	31,424		2,095	31,424	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,310	139,649		9,310	139,649	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				56,267		56,267	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	20,694	\$ 310,413	\$ 56,298	20,694	\$ 366,711	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	\$ (1,087,331)	\$ (1,087,331)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 157,745)	1,911,530	1,911,530	3
4	Supply Inventory (priced at Cost)	16,862	16,862	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,730	42,183	6
7	Other Prepaid Expenses		25,766	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	3,681	3,681	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 872,472	\$ 912,691	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		123,750	13
14	Buildings, at Historical Cost		2,175,042	14
15	Leasehold Improvements, at Historical Cost	16,994	395,199	15
16	Equipment, at Historical Cost	13,259	555,585	16
17	Accumulated Depreciation (book methods)	(4,482)	(1,643,548)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		188,175	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(19,245)	20
21	Restricted Funds		263,207	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,771	\$ 2,038,165	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 898,243	\$ 2,950,856	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 571,602	\$ 571,602	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,381	100,381	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,908	33,908	31
32	Accrued Real Estate Taxes(Sch.IX-B)		41,940	32
33	Accrued Interest Payable		8,394	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	354,998	354,998	36
37	Accrued Management Fees	15,456	15,456	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,076,345	\$ 1,126,679	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,616,340	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	464,043	(118,586)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 464,043	\$ 2,497,754	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,540,388	\$ 3,624,433	46
47	TOTAL EQUITY(page 18, line 24)	\$ (642,145)	\$ (673,577)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 898,243	\$ 2,950,856	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,113,965)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(11,975)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,125,940)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	402,033	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	81,762	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)	\$ 483,795	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)	\$ (642,145)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fondulac Rehab & Hlth Care C

0047472

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 3,621,356	1
2	Discounts and Allowances for all Levels	(209,960)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,411,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	580,171	6
7	Oxygen	1,465	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 581,636	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	1,335	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,051	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	732	19
20	Radiology and X-Ray	12,539	20
21	Other Medical Services	9,240	21
22	Laundry	63	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 122,960	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	753	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 753	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	5,805	28
28a	<u>Miscellaneous Revenue</u>	1,450	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,255	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,124,000	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	701,171	31
32	Health Care	1,720,081	32
33	General Administration	574,301	33
	B. Capital Expense		
34	Ownership	353,150	34
	C. Ancillary Expense		
35	Special Cost Centers	191,828	35
36	Provider Participation Fee	181,436	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,721,967	40
41	Income before Income Taxes (line 30 minus line 40)**	402,033	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 402,033	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,388,361	44
45	Private Pay - Net Inpatient Revenue	462,089	45
46	Medicare - Net Inpatient Revenue	434,884	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	126,062	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,411,396	49

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

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

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

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

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	2,067	2,067	\$ 61,051	\$ 29.54	1
2	Assistant Director of Nursing	610	610	12,639	20.72	2
3	Registered Nurses	7,724	7,886	201,368	25.53	3
4	Licensed Practical Nurses	15,093	15,482	312,612	20.19	4
5	CNAs & Orderlies	39,512	40,426	498,949	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,073	2,073	32,942	15.89	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	43,422	20.88	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	40,655	19.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,306	13,141	148,972	11.34	15
16	Dishwashers					16
17	Maintenance Workers	1,918	1,982	37,554	18.95	17
18	Housekeepers	15,123	15,439	150,083	9.72	18
19	Laundry					19
20	Administrator	2,080	2,080	69,375	33.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,060	2,060	30,866	14.98	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					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	7,091	7,096	118,873	16.75	33
34	TOTAL (lines 1 - 33)	111,817	114,502	\$ 1,759,361 *	\$ 15.37	34

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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,054	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	231	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)	4	\$ 17,285		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4	\$ 122	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4	\$ 122		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Fondulac Rehab & Hlth Care C
0047472
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages
		Average Hourly Wage		
Care Plan Coordinator		2,067	2,067	51,442
Transportation		2,944	2,949	27,772
Marketing		2,080	2,080	39,659
TOTAL		7,091	7,096	118,873

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Doug Harridge	Administrator	0	\$ 69,375
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,375
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 287,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 287,700
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 3,005
Peoria County Circuit Clerk	Filing Fees		40
Comcast Cable	Computer Services		1,258
Honkamp Krueger & Co.	Accounting Services		3,473
Ability Network	Computer Services		102
Fondulac Petty Cash	Computer Services		29
Quinn, Johnston	Refund Legal Fees		(6,489)
Capitol Finance Group	Refund Refinance Fees		(6,320)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ (4,901)
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 33,580
Unemployment Compensation Insurance			37,722
FICA Taxes			126,836
Employee Health Insurance			268
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			2,681
Home Office Allocation			31,214
TOTAL (agree to Schedule V, line 22, col.8)			\$ 232,301
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			813
Health Care Worker Background Check (Indicate # of checks performed)	30		467
Patient Background Checks	38		595
Miscellaneous Licenses & Permits			1,437
Miscellaneous Dues & Subscriptions			4,446
Home Office Allocation			510
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 12,248
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			52
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 52

*** Attach copy of IMRF notifications**

****See instructions.**

Fondulac Rehab & Hlth Care C
0047472

Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(4,901)
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	54
Miscellaneous	Legal	17
Miller Hall and Triggs	Legal	94
Healthcare Resources International	Legal	470
Hunziker Law	Legal	112
Lexis Nexis	Legal	10
Illinois Secretary of State	Legal	33
Lane and Waterman	Legal	192
Quinn and Johnston	Legal	853
Peoria County Recorder	Legal	24
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	489
Ginoli & Co.	Accountants	6,795
Capital Finance Group	Accountants	7,600
Miscellaneous	Computer Services	62
Change Healthcare	Computer Services	9
PTC Select	Computer Services	6
Advanced Answers on Demand	Computer Services	4,293
Stratus Networks	Computer Services	437
Kemper Technology	Computer Services	288
AT&T	Computer Services	6
Ability Network	Computer Services	1,830
CIAN	Computer Services	218
Comcast	Computer Services	36
CCH	Computer Services	14
Charter Communications	Computer Services	42
Allscripts	Computer Services	638
ATS	Computer Services	288
Allpayer Exchange	Computer Services	15
Optimizer	Other Prof Fees	44
Ankura	Other Prof Fees	333
David Budde	Other Prof Fees	38
Bruner, Cooper, Zuck	Other Prof Fees	97
Marotta, Gund, Budd, Dzerda	Other Prof Fees	5,671
Professional Software and Services	Other Prof Fees	24
Hughes Valuation Services	Other Prof Fees	30
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8) 26,513

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?
If YES, give association name and amount.

Yes
IHCA \$4446
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 24,930 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9)

Are you presently operating under a sublease agreement?

YES X NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 181,436
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 1,335
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 5,805

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

No

RECONCILIATION REPORT			Fondulac Rehab & Hlth		10:07 AM	7/7/2017							
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-197,585	equal to	-197,585	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	120,442	equal to	120,442	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	41,523	equal to	41,523	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	11,408	equal to	11,408	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	141,003	equal to	141,003	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	41,470	equal to	41,470	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	310,444	equal to	310,444	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	56,298	equal to	56,298	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	701,171	equal to	701,171	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,720,081	equal to	1,720,081	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	574,301	equal to	574,301	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	353,150	equal to	353,150	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	191,828	equal to	191,828	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	181,436	equal to	181,436	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,138,061	equal to	1,138,061	0	O.K.	Pg20 K11..,K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	60,714	equal to	60,714	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	43,422	equal to	43,422	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	189,627	equal to	189,627	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	37,554	equal to	37,554	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	150,083	equal to	150,083	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		#VALUE!	#VALUE!	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	69,375	equal to	69,375	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	30,866	equal to	30,866	0	O.K.	Pg20 K33..,K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,759,361	equal to	1,689,986	69,375	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	5,407	< or = to	15,105	-9,698	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	69,375	equal to	69,375	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	287,700	equal to	287,700	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	-4,901	equal to	-4,901	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	232,301	equal to	232,301	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	12,248	equal to	12,248	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	52	equal to	52	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	181,436	equal to	181,436	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..,U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,035	equal to	2,281	-246	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-58,354	equal to	-58,354	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	2,616,340	equal to	2,616,340	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	41,940	equal to	41,940	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	123,750	equal to	123,750	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,570,241	equal to	2,570,241	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	555,585	equal to	555,585	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,643,548	equal to	1,643,548	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-642,145	equal to	-642,145	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	402,033	equal to	402,033	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	898,243	equal to	898,243	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	189,627	12,300	0	201,927	0	201,927	4,789	206,716
2. Food Purchase	0	150,345	0	150,345	0	150,345	-1,248	149,097
3. Housekeeping	150,083	22,235	0	172,318	0	172,318	84	172,402
4. Laundry	0	12,690	0	12,690	0	12,690	0	12,690
5. Heat and Other Utilities	0	0	81,630	81,630	0	81,630	279	81,909
6. Maintenance	37,554	25,088	19,619	82,261	0	82,261	7,335	89,596
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	377,264	222,658	101,249	701,171	0	701,171	11,239	712,410
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	1,138,061	139,974	15,105	1,293,140	0	1,293,140	-1,205	#####
10a. Therapy	0	31	310,413	310,444	0	310,444	0	310,444
11. Activities	60,714	361	0	61,075	0	61,075	-5,805	55,270
12. Social Services	43,422	0	0	43,422	0	43,422	0	43,422
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,242,197	140,366	337,518	1,720,081	0	1,720,081	-7,010	#####
17. Administrative	0	0	287,700	287,700	0	287,700	-218,325	69,375
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	-4,901	-4,901	0	-4,901	31,415	26,514
20. Fees, Subscriptions & Promotion	0	0	11,738	11,738	0	11,738	510	12,248
21. Clerical & General Office	30,866	2,766	13,083	46,715	0	46,715	58,734	105,449
22. Employee Benefits & Payroll	0	0	201,087	201,087	0	201,087	31,214	232,301
23. Inservice Training & Education	0	0	0	0	0	0	107	107
24. Travel and Seminar	0	0	0	0	0	0	52	52
25. Other Admin. Staff Trans	0	0	7,828	7,828	0	7,828	4,392	12,220
26. Insurance-Prop.Liab.Malpractice	0	0	24,134	24,134	0	24,134	22,952	47,086
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	30,866	2,766	540,669	574,301	0	574,301	-68,949	505,352
29. Total General Administrative	1,650,327	365,790	979,436	2,995,553	0	2,995,553	-64,720	#####
30. Depreciation	0	0	2,436	2,436	0	2,436	138,567	141,003
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	11,408	11,408
32. Interest	0	0	0	0	0	0	120,442	120,442
33. Real Estate	0	0	0	0	0	0	41,523	41,523
34. Rent - Facility & Grounds	0	0	310,248	310,248	0	310,248	-310,248	0
35. Rent - Equipment & Vehicles	0	0	40,466	40,466	0	40,466	1,004	41,470
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	353,150	353,150	0	353,150	2,696	355,846
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	56,267	0	56,267	0	56,267	0	56,267
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	181,436	181,436	0	181,436	0	181,436
43. Other (specify):*	39,659	728	95,174	135,561	0	135,561	-135,561	0
44. Total Special Cost Ce	39,659	56,995	276,610	373,264	0	373,264	-135,561	237,703
45. Grand Total	1,689,986	422,785	1,609,196	3,721,967	0	3,721,967	-197,585	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	#####	-1,087,331
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,911,530	1,911,530
4. Supply Inventory	16,862	16,862
5. Short-Term Investments	0	0
6. Prepaid Insurance	27,730	42,183
7. Other Prepaid Expenses	0	25,766
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	3,681	3,681
10. Total current assets	872,472	912,691
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	123,750
14. Buildings, at Historical Cost	0	2,175,042
15. Leasehold Improvements, Historical Cost	16,994	395,199
16. Equipment, at Historical Cost	13,259	555,585
17. Accumulated Depreciation (book methods)	-4,482	-1,643,548
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	188,175
20. Accum Amort - Org/Pre-Op Costs	0	-19,245
21. Restricted Funds	0	263,207
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	25,771	2,038,165
25. Total Assets	898,243	2,950,856
CURRENT LIABILITIES		
26. Accounts Payable	571,602	571,602
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	100,381	100,381
31. Accrued Taxes Payable	33,908	33,908
32. Accrued Real Estate Taxes	0	41,940
33. Accrued Interest Payable	0	8,394
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	354,998	354,998
37. Other Current Liabilities (specify):	15,456	15,456
38. Total Current Liabilities	1,076,345	1,126,679
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,616,340
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	464,043	-118,586
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	464,043	2,497,754
46.Total Liabilities	1,540,388	3,624,433
47.Total Equity	-642,145	-673,577
48.Total Liabilities and Equity	898,243	2,950,856

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,621,356
2. Discounts and Allowances for all Levels	-209,960
Subtotal - Inpatient Care	3,411,396
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	580,171
7. Oxygen	1,465
Subtotal - Ancillary Revenue	581,636
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,335
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	99,051
18. Sale of Supplies to Non-Patients	0
19. Laboratory	732
20. Radiology and X-Ray	12,539
21. Other Medical Services	9,240
22. Laundry	63
Subtotal - Other Operating Revenue	122,960
24. Contributions	0
25. Interest and Other Investments Income	753
Subtotal - Non-Operating Revenue	753
27. Other Revenue (specify):	5,805
28. Other Revenue (specify):	1,450
Subtotal - Other Revenue	7,255
30. Total Revenue	4,124,000
31. General Services	713,166
32. Health Care	1,518,109
33. General Administration	567,616
34. Ownership	362,187
35. Special Cost Centers	205,183
35. Provider Participation Fee	186,007
37. Other	0
40. Total Expenses	3,552,268
41. Income Before Income Taxes	571,732
42. Income Taxes	0
43. Net Income or Loss for the Year	571,732