		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0047472

Facility Name: Fondulac Rehab Health Care C

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

County: Tazewell

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
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 1/1/2020 to 12/31/2020 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 Petersen
(Title) Chief Executive Officer

Paid Preparer

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

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,354	738	1,116	20,208	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,354	738	1,116	20,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.49%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 845

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	160,455	18,729		179,184		179,184	5,381	184,565			1
2	Food Purchase		135,142		135,142		135,142	(1,023)	134,119			2
3	Housekeeping	125,525	26,942		152,467		152,467	104	152,571			3
4	Laundry	12,419	9,456		21,875		21,875		21,875			4
5	Heat and Other Utilities			82,869	82,869		82,869	367	83,236			5
6	Maintenance	31,578	8,921	33,318	73,817		73,817	4,428	78,245			6
7	Other (specify):*											7
8	**TOTAL General Services**	329,977	199,190	116,187	645,354		645,354	9,257	654,611			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,054,765	89,220	305,398	1,449,383		1,449,383	5,512	1,454,895			10
10a	Therapy			146,118	146,118		146,118		146,118			10a
11	Activities	60,826	(1,209)		59,617		59,617	835	60,452			11
12	Social Services	48,696			48,696		48,696		48,696			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,164,287	88,011	463,516	1,715,814		1,715,814	6,347	1,722,161			16
	C. General Administration											
17	Administrative	72,504		186,100	258,604		258,604	(156,176)	102,428			17
18	Directors Fees											18
19	Professional Services			24,461	24,461		24,461	125,793	150,254			19
20	Dues, Fees, Subscriptions & Promotions			8,430	8,430		8,430	2,145	10,575			20
21	Clerical & General Office Expenses	32,240	3,917	14,232	50,389		50,389	35,398	85,787			21
22	Employee Benefits & Payroll Taxes			177,733	177,733		177,733	21,778	199,511			22
23	Inservice Training & Education							55	55			23
24	Travel and Seminar							17	17			24
25	Other Admin. Staff Transportation			4,084	4,084		4,084	3,855	7,939			25
26	Insurance-Prop.Liab.Malpractice			40,338	40,338		40,338	25,035	65,373			26
27	Other (specify):*											27
28	**TOTAL General Administration**	104,744	3,917	455,378	564,039		564,039	57,900	621,939			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,599,008	291,118	1,035,081	2,925,207		2,925,207	73,504	2,998,711			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fondulac Rehab Health Care C #0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			4,312	4,312		4,312	130,890	135,202			30
31	Amortization of Pre-Op. & Org.							8,553	8,553			31
32	Interest							91,037	91,037			32
33	Real Estate Taxes							44,976	44,976			33
34	Rent-Facility & Grounds			265,537	265,537		265,537	(265,537)				34
35	Rent-Equipment & Vehicles			13,857	13,857		13,857	10,819	24,676			35
36	Other (specify):*											36
37	**TOTAL Ownership**			283,706	283,706		283,706	20,738	304,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,821		32,821		32,821		32,821			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,989	154,989		154,989		154,989			42
43	Other (specify):*	45,900	79	115,191	161,170		161,170	(161,170)				43
44	**TOTAL Special Cost Centers**	45,900	32,900	270,180	348,980		348,980	(161,170)	187,810			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,644,908	324,018	1,588,967	3,557,893		3,557,893	(66,928)	3,490,965			45

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,023)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,079)	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	3,598	30		9
10	Interest and Other Investment Income	(80)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(87)	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	(30,491)	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	(51,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,909)	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	(85,643)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (175,714)		$	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)	108,786	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 108,786		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (66,928)		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

Fondulac Rehab Health Care C

ID# 0047472

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (18,629)	43	1
2	X-Rays-Part A	(3,184)	43	2
3	Offset Transportation Revenue	835	11	3
4	Disallowed Pet Expense	(891)	43	4
5	Disallowed Chamber of Commerece Dues	(610)	20	5
6	Offset Miscellaneous Nursing Supplies Revenue	(2,199)	10	6
7	Offset Miscellaneous Office Supplies Revenue	(65)	21	7
8	Non-Allowable Legal Settlement	(15,000)	19	8
9	Disallowed Marketing Salaries	(45,900)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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**	(85,643)		49

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 5,381	$ 5,381	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	104	104	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	367	367	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,232	3,232	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%	5,042	5,042	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	186,100	Petersen Health Care Management, Inc.	100.00%	29,924	(156,176)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	17,675	17,675	12
13	V								13
14	Total			$ 186,100			$ 61,725	$ * (124,375)	14

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 2,755	$ 2,755	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	33,363	33,363	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	9,159	9,159	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	55	55	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	17	17	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,855	3,855	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	588	588	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	5,447	5,447	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	265	265	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	212	212	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,954	1,954	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			$			$ 57,670	$ * 57,670	39

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	2,669	2,669	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%	116,413	116,413	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%	12,619	12,619	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%	0		33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	8,990	8,990	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%	8,865	8,865	38
39	Total			$			$ 149,556	$ * 149,556	39

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Fondulac Land, LLC	100.00%	$ 1,196	$ 1,196	15
16	V	19	Professional Services	$	Fondulac Land, LLC	100.00%	6,705	6,705	16
17	V	21	Equipment		Fondulac Land, LLC	100.00%	2,100	2,100	17
18	V	26	Insurance-Property		Fondulac Land, LLC	100.00%	9,613	9,613	18
19	V	26	Insurance-Mortgage Insurance		Fondulac Land, LLC	100.00%	14,834	14,834	19
20	V	30	Depreciation		Fondulac Land, LLC	100.00%	121,845	121,845	20
21	V	31	Amortization		Fondulac Land, LLC	100.00%	8,553	8,553	21
22	V	32	Interest	831	Fondulac Land, LLC	100.00%	82,693	81,862	22
23	V	33	Real Estate Taxes		Fondulac Land, LLC	100.00%	44,764	44,764	23
24	V	34	Rent-Income and Grounds	265,537	Fondulac Land, LLC	100.00%		(265,537)	24
25	V								25
26	V								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			$ 266,368			$ 292,303	$ * 25,935	39

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Syster	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 Quali	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 Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			Betty's Garden	Kewanee				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 Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Petersen Health Care 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	$ 341,562	$ 398,718	20,208	$ 5,381	1
2	2	Food	Resident Days	1,282,791	75	0	0	20,208	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	20,208	104	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	20,208	367	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	20,208	3,232	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	20,208	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	20,208	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	20,208	5,042	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	20,208	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	20,208	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	20,208	29,924	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	20,208	17,675	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	20,208	2,755	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	20,208	33,363	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	20,208	9,159	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	20,208	55	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	20,208	17	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	20,208	3,855	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	20,208	588	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	20,208	5,447	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	20,208	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	20,208	265	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	20,208	212	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	20,208	1,954	24
25	TOTALS					$ 7,579,077	$ 11,195,006		$ 119,395	25

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Petersen Health Operations, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: ((309)691-8113
Fax Number: ((309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	163,986	9	$	$	20,208	$	1
2	2	Food	Resident Days	163,986	9			20,208		2
3	3	Housekeeping	Resident Days	163,986	9			20,208		3
4	4	Laundry	Resident Days	163,986	9			20,208		4
5	5	Utilities	Resident Days	163,986	9			20,208		5
6	6	Maintenance	Resident Days	163,986	9			20,208		6
7	7	Mgmt. Allocation of Benefits	Resident Days	163,986	9			20,208		7
8	10	Nursing and Medical Records	Resident Days	163,986	9	21,660		20,208	2,669	8
9	15	Mgmt. Allocation of Benefits	Resident Days	163,986	9			20,208		9
10	17	Administrative	Resident Days	163,986	9			20,208		10
11	19	Professional Services	Resident Days	163,986	9	944,677		20,208	116,413	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	163,986	9			20,208		12
13	21	Clerical and General Office	Resident Days	163,986	9			20,208		13
14	22	Employee Benefits & Payroll	Resident Days	163,986	9	102,400		20,208	12,619	14
15	23	Inservice Training & Education	Resident Days	163,986	9			20,208		15
16	24	Travel and Seminar	Resident Days	163,986	9			20,208		16
17	25	Other Admin. Staff Transport.	Resident Days	163,986	9			20,208		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	163,986	9			20,208		18
19	30	Depreciation	Resident Days	163,986	9			20,208		19
20	31	Amortization	Resident Days	163,986	9			20,208		20
21	32	Interest	Resident Days	163,986	9	72,956		20,208	8,990	21
22	33	Real Estate Taxes	Resident Days	163,986	9			20,208		22
23	34	Rent-Facility and Grounds	Resident Days	163,986	9			20,208		23
24	35	Rent-Equipment & Vehicles	Resident Days	163,986	9	71,940		20,208	8,865	24
25	TOTALS					$ 1,213,633	$		$ 149,556	25

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 2,236,009	12/31/34	Varies	$ 82,693	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,799,200	$ 2,236,009			$ 82,693	9
	B. Non-Facility Related*											
10								Interest Income Offset			(911)	10
11								Home Office Allocation-PHCM			265	11
12								Home Office Allocation-PHO			8,990	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,344	14
15	TOTALS (line 9+line14)						$ 2,799,200	$ 2,236,009			$ 91,037	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 14,834 Line # 26

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

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 43,620	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.)		$ 43,540	2
3. Under or (over) accrual (line 2 minus line 1).		$ (80)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 44,844	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. **Home Office Allocation**		212	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 44,976	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	40,721	8
	2016	41,036	9
	2017	41,959	10
	2018	42,351	11
	2019	43,540	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-26-300-009	Long-Term Care Facility	$ 43,539.74	$ 43,539.74
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,539.74	$ 43,539.74

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

N/A

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

1. Total Amount Incurred: 188,175 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 8,553 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 1,342,145	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	500	500	15,000	9
10	Sidewalks			2006	3,200		15	213	213	3,089	10
11	Fire Alarm system			2006	4,030		10			4,030	11
12	Replace water main			2006	4,600		25	184	184	2,668	12
13	Water heater replacement			2006	3,097		10			3,097	13
14	Cubicle Curtains			2007	5,193		20	260	260	3,458	14
15	Door Alarm			2007	1,697		15	113	113	1,582	15
16	Fire Alarm			2007	1,854		15	124	124	1,736	16
17	Blinds & Valances			2007	4,699		10			4,699	17
18	Wallpaper for 3 Halls & Front Lobby			2007	2,258		15	151	151	1,988	18
19	Painting for all rooms, office area, bathrooms, hallways			2007	13,436		15	896	896	12,040	19
20	Carpeting for Hallways			2007	6,541		15	436	436	5,834	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	11,150	23
24	Generator Repair			2009	2,599		7			2,599	24
25	Compressor Repair			2009	2,971		7			2,971	25
26	Freezer Repair			2009	3,445		7			3,445	26
27	Landscaping			2010	4,850		15	324	324	3,402	27
28	Cabinetry-Nursing Stations			2010	14,218		15	948	948	9,954	28
29	Carpet and Tiling in Nursing Stations and Kitchen			2010	15,811		15	1,054	1,054	6,966	29
30	Water Softener			2011	2,974		7			2,974	30
31	Water Heater			2011	5,737		7			5,737	31
32	Water Heater			2011	2,989		7			2,989	32
33	Tile Replacement in Showers			2011	15,567		15	1,038	1,038	9,342	33
34	Roof Replacement on North Section			2011	49,142		25	1,966	1,966	18,677	34
35	Water Main Repair			2012	3,602		7			3,602	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 Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Line Repair	2013	$ 10,932	$	7	$ 779	$ 779	$ 10,932	37
38	Bathroom Fixtures	2013	2,809		7	196	196	2,809	38
39	Blacktopping	2013	10,500		7	750	750	10,500	39
40	Painting-Exterior	2013	11,071		15	738	738	5,535	40
41	Alarm System Panel Replacement	2013	4,273		7	308	308	4,273	41
42	Tile Replacement in Hallways and Kitchen	2014	13,185		15	879	879	5,714	42
43	Landscaping Around Building	2014	21,897		15	1,460	1,460	9,490	43
44	Landscaping Around Building	2014	8,944		15	596	596	3,874	44
45	Copper Line Repair	2015	3,241		7	464	464	2,552	45
46	Nurses Station Replacement	2015	8,982		7	1,284	1,284	7,062	46
47	Plumbing Repairs	2015	9,170		7	1,310	1,310	7,205	47
48	Water Softener Replacement	2015	6,126		7	876	876	4,818	48
49	Dumpster Pads	2015	19,686		15	1,312	1,312	7,216	49
50	Air Conditioner	2016	6,250		15	416	416	1,872	50
51	Water Sprinkler System Repair	2016	11,448		7	1,636	1,636	7,362	51
52	Exterior Landscaping	2016	8,050		7	1,150	1,150	5,175	52
53	Plumbing Repairs	2017	6,847		7	978	978	3,423	53
54	Fire Alarm System Repair	2017	3,944		7	564	564	1,974	54
55	Water Heater-65 Gallon	2017	7,405		7	1,058	1,058	3,703	55
56	Air Conditioner	2017	7,400		15	494	494	1,729	56
57	Water Pipe Repairs	2018	6,275		7	896	896	2,240	57
58	Heating/Cooling Units	2019	20,068		15	1,338	1,338	2,007	58
59	Sprinkler Repair	2020	9,077		7	648	648	648	59
60	Water Heater	2020	10,189		7	728	728	728	60
61									61
62									62
63	Land Improvements Booked			2,178			(2,178)		63
64	Building Booked			86,320			(86,320)		64
65	Building Improvement Booked			27,317			(27,317)		65
66									66
67	2020-Home Office Allocation-Building Improvements		10,217			245	245		67
68	2020-Home Office Allocation-Land Improvements		1,025			65	65		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,641,449	$ 115,815		$ 116,857	$ 1,042	$ 1,611,443	70

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 124,843	$ 9,097	$ 12,013	$ 2,916	5-10 yrs.	$ 93,194	71
72	Current Year Purchases	16,732	1,245	1,195	(50)	7 yrs.	1,195	72
73	Fully Depreciated Assets	454,999					454,999	73
74	Home Office Allocation			5,137	5,137			74
75	TOTALS	$ 596,574	$ 10,342	$ 18,345	$ 8,003		$ 549,388	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,361,773	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,157	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 135,202	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,045	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,160,831	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			93
94			94
95		$	95

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

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 24,676 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 Health Care C
0047472
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	7,401
Dishwasher		701
Copier		5,755
Home Office Allocation		10,819
		24,676

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

   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	$	4,946	$ 74,186	$	4,946	$ 74,186	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		152	21,774		152	21,774	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,344	50,158		3,344	50,158	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				32,821		32,821	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	8,442	$ 146,118	$ 32,821	8,442	$ 178,939	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 924,100	$ 924,100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,845)	3,123,257	3,123,257	3
4	Supply Inventory (priced at Cost)	16,862	16,862	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,242	36,851	6
7	Other Prepaid Expenses		27,695	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	2,925	2,925	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,087,386	$ 4,131,690	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		2,174,967	14
15	Leasehold Improvements, at Historical Cost	28,210	466,482	15
16	Equipment, at Historical Cost	27,118	596,574	16
17	Accumulated Depreciation (book methods)	(15,863)	(2,160,831)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		188,175	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(53,459)	20
21	Restricted Funds		295,571	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	61,452	99,440	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 100,917	$ 1,730,669	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,188,303	$ 5,862,359	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 642,226	$ 648,501	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,507	91,507	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		44,844	32
33	Accrued Interest Payable		7,174	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	91,758	91,758	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 825,491	$ 883,784	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,236,009	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	1,000,000	1,000,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,000,000	$ 3,236,009	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,825,491	$ 4,119,793	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,362,812	$ 1,742,566	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,188,303	$ 5,862,359	48

***(See instructions.)**

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,630,319	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	(285,983)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,344,336	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,018,476	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)**	$ 1,018,476	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)**	$ 2,362,812	24 *

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,033,220	1
2	Discounts and Allowances for all Levels	(623,725)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,409,495	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,806	6
7	Oxygen	715	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 241,521	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	1,023	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,093	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,024	19
20	Radiology and X-Ray	11,660	20
21	Other Medical Services	3,674	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 68,474	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	(835)	28
28a	Miscellaneous and Illinois Cares Revenue	857,634	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 856,799	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,576,369	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	645,354	31
32	Health Care	1,715,814	32
33	General Administration	564,039	33
	B. Capital Expense		
34	Ownership	283,706	34
	C. Ancillary Expense		
35	Special Cost Centers	193,991	35
36	Provider Participation Fee	154,989	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,557,893	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,018,476	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,018,476	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,834,108	44
45	Private Pay - Net Inpatient Revenue	140,102	45
46	Medicare - Net Inpatient Revenue	304,648	46
47	Other-(specify) Insurance Net Inpatient Revenue	130,637	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,409,495	49

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

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

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

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

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,907	1,907	$ 74,875	$ 39.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,794	2,872	86,010	29.95	3
4	Licensed Practical Nurses	11,129	11,582	291,753	25.19	4
5	CNAs & Orderlies	32,974	33,532	489,090	14.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	37,767	18.16	9
10	Activity Assistants	985	990	12,897	13.03	10
11	Social Service Workers	2,080	2,080	48,696	23.41	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	45,747	21.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,156	9,803	114,708	11.70	15
16	Dishwashers					16
17	Maintenance Workers	1,626	1,682	31,578	18.77	17
18	Housekeepers	10,668	11,197	125,525	11.21	18
19	Laundry	1,055	1,071	12,419	11.60	19
20	Administrator	1,917	2,038	72,504	35.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,736	1,759	32,240	18.33	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	2,018	2,091	54,950	26.28	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	377	377	8,615	22.85	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,563	4,571	105,534	23.09	33
34	TOTAL (lines 1 - 33)	89,145	91,712	$ 1,644,908 *	$ 17.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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	6,161	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	16	805	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)	16	$ 18,966		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,443	71,598	L10,C3	51
52	Certified Nurse Assistants/Aides	10,116	226,834	L10,C3	52
53	TOTAL (lines 50 - 52)	11,559	$ 298,432		53

Fondulac Rehab Health Care C
0047472
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,518	1,526	49,472	32.42
Transportation	945	945	10,162	10.75
Marketing	2,100	2,100	45,900	21.86
TOTAL	4,563	4,571	105,534	

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debbie Snow	Administrator	0	$ 21,738
Chad Dawson	Administrator	0	50,766
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,504

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 186,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 186,100

C. Professional Services

Vendor/Payee	Type	Amount
Comcast Cable	Computer Services	$ 1,300
Ability Network	Computer Services	7,054
Gay Grant-McLennon	Legal Settlement-1/13/20	15,000
Medicare Benefit Coordination	Legal Fees-1/13/20	1,107
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 24,461

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,730
Unemployment Compensation Insurance	16,776
FICA Taxes	118,199
Employee Health Insurance	3,472
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	460
Home Office Allocation	21,778
Administrator Benefits	15,096
TOTAL (agree to Schedule V, line 22, col.8)	$ 199,511

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 30)	
Patient Background Checks 110	3,310
Miscellaneous Licenses & Permits	530
Miscellaneous Dues & Subscriptions	610
Home Office Allocation	2,755
Less: Public Relations Expense	(610)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,575

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	17
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17

**See instructions.

Fondulac Rehab Health Care C
0047472
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		24,461
Non Allowable Legal Settlement		(15,000)
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	464
Duane Morris	Legal	33,574
Lexis Nexis	Legal	8
Livingston, Barger, Brant, Schroeder	Legal	14,045
Miller, Hall, Triggs	Legal	54
Miscellaneous	Legal	20
SB2	Legal	929
SmithAmundsen LLC	Legal	2,213
Sorling Northrup	Legal	532
Capital Finance Group	Legal	4,455
Illinois Secretary of Sate	Legal	148
McGuire Woods	Legal	6,162
CliftonLarsonAllen	Accounting	1,235
Ginoli & Co.	Accounting	10,925
Ability Network	Computer Services	3,172
Allscripts	Computer Services	501
AOD Matrix Care	Computer Services	5,571
AT&T	Computer Services	6
ATS	Computer Services	304
CCH	Computer Services	18
Charter Communications	Computer Services	28
Citrix Systems	Computer Services	95
Comcast	Computer Services	32
ITSavvy	Computer Services	147
Kemper Technology	Computer Services	724
Miscellaneous	Computer Services	140
Pearl Technology	Computer Services	131
Stratus Networks	Computer Services	575
TR Professional	Computer Services	12
Creative Health Capital	Other Prof Fees	4,983
Mohr and Kerr	Other Prof Fees	9,078
Planning and Zoning Resource Company	Other Prof Fees	1,275
David Budde	Other Prof Fees	13
DJ Howard and Associates	Other Prof Fees	1,195
Getzler Henrich & Associates	Other Prof Fees	1,285
LRI Consulting Services	Other Prof Fees	1,298
McQuellon Consulting	Other Prof Fees	799
Miscellaneous	Other Prof Fees	114
Optimizer	Other Prof Fees	52
Registered Agent Solutions	Other Prof Fees	29
RSM McGladrey	Other Prof Fees	315
SB2	Other Prof Fees	402
Sedgwick CMS	Other Prof Fees	33,660
Tarver Program Consultants	Other Prof Fees	75
Total (agree to Schedule V, line 19, column 8)		150,254

Fondulac Rehab Health Care C
0047472
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	2,020
Auto Repairs		1,503
Mileage-Travel		561
Home Office Allocation		3,855
		7,939

Facility Name & ID Number Fondulac Rehab Health Care C # 0047472 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,317** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **154,989**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,023**

(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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **No**
Attach invoices and a summary of services for all architect and appraisal fees.