FOR BHF USE

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

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

I. IDPH License ID Number: 0047589

Facility Name: Vandalia Rehabilitation & Health Care Center

Address: 1500 West St Louis Avenue (Number) Vandalia (City) 62471 (Zip Code)

County: Fayette

Telephone Number: (618) 283-4262 **Fax #** (618) 283-4313

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2005

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: Larry Templin **Telephone Number:** (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 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	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	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			2,717	2,717	8
9	SNF/PED					9
10	ICF	12,587	2,033		14,620	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,587	2,033	2,717	17,337	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.95%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 10/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 2,645

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Cente # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	118,780	11,642		130,422		130,422	3,229	133,651			1
2	Food Purchase		100,919		100,919		100,919	(4,931)	95,988			2
3	Housekeeping	69,493	16,803		86,296		86,296	38	86,334			3
4	Laundry	41,733	13,089		54,822		54,822		54,822			4
5	Heat and Other Utilities			79,954	79,954		79,954	321	80,275			5
6	Maintenance	35,646	16,662	22,016	74,324		74,324	1,879	76,203			6
7	Other (specify):* Home Off. Ben. All.							757	757			7
8	TOTAL General Services	265,652	159,115	101,970	526,737		526,737	1,293	528,030			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	769,397	79,288	4,425	853,110		853,110	49	853,159			10
10a	Therapy			302,825	302,825		302,825		302,825			10a
11	Activities	37,749	329	(1,067)	37,011		37,011	(4,367)	32,644			11
12	Social Services	23,306			23,306		23,306		23,306			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	830,452	79,617	315,783	1,225,852		1,225,852	(4,318)	1,221,534			16
	C. General Administration											
17	Administrative			201,000	201,000		201,000	(150,047)	50,953			17
18	Directors Fees											18
19	Professional Services			4,651	4,651		4,651	4,342	8,993			19
20	Dues, Fees, Subscriptions & Promotions			7,220	7,220		7,220	964	8,184			20
21	Clerical & General Office Expenses	41,565	6,342	7,300	55,207		55,207	33,539	88,746			21
22	Employee Benefits & Payroll Taxes			258,556	258,556		258,556	2,796	261,352			22
23	Inservice Training & Education			317	317		317	231	548			23
24	Travel and Seminar							27	27			24
25	Other Admin. Staff Transportation			7,125	7,125		7,125	2,892	10,017			25
26	Insurance-Prop.Liab.Malpractice			44,819	44,819		44,819	479	45,298			26
27	Other (specify):* Home Off. Ben. All.							13,116	13,116			27
28	TOTAL General Administration	41,565	6,342	530,988	578,895		578,895	(91,661)	487,234			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,137,669	245,074	948,741	2,331,484		2,331,484	(94,686)	2,236,798			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 Vandalia Rehabilitation & Health Care Center #0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,292	51,292		51,292	293	51,585			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,945	31,945		31,945	22,873	54,818			32
33	Real Estate Taxes			42,634	42,634		42,634	(402)	42,232			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,094	27,094		27,094	443	27,537			35
36	Other (specify):*											36
37	**TOTAL Ownership**			152,965	152,965		152,965	23,207	176,172			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,795		106,795		106,795		106,795			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):* Non-allowable Cost		1,549	73,666	75,215		75,215	(75,215)				43
44	**TOTAL Special Cost Centers**		108,344	137,176	245,520		245,520	(75,215)	170,305			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,137,669	353,418	1,238,882	2,729,969		2,729,969	(146,694)	2,583,275			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 Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,931)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,288)	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	(4,282)	30		9
10	Interest and Other Investment Income	(339)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,637)	43		24
25	Fund Raising, Advertising and Promotional	(4,212)	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	(16,696)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,695)		$	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)	(55,999)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (55,999)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (146,694)		37

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

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

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

STATE OF ILLINOIS

Vandalia Rehabilitation & Health Care Center

ID# 0047589

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (9,950)	43	1
2	X-Rays-Part A	(163)	43	2
3	Disallow Real Estate Tax penalty	(861)	33	3
4	Offset Transportation Revenue	(4,367)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(42)	21	5
6	Resident Flowers	(438)	43	6
7	Disallowed Special Events	(217)	43	7
8	Nonallowable Dues	(658)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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**	(16,696)		49

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See Attached Schedule 6E		See Attached Sch. 6E		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,229	$ 3,229	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	38	38	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	321	321	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,879	1,879	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	757	757	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	49	49	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	201,000	Petersen Health Care, Inc.	100.00%	50,953	(150,047)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,578	3,578	12
13	V								13
14	Total			$ 201,000			$ 60,804	$ * (140,196)	14

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 886	$ 886	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	32,141	32,141	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	231	231	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	27	27	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,892	2,892	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	479	479	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,116	13,116	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,720	3,720	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,287	4,287	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	459	459	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	443	443	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			$			$ 58,681	$ * 58,681	39

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12	Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	764	764	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	736	736	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,440	1,440	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	2,796	2,796	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	855	855	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	18,925	18,925	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			$			$ 25,516	$ * 25,516	39

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Cent # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	180,047	0.66	1.10	Salary	$ 2,203	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,203		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 Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,527,029	77	$ 284,427	$ 283,010	17,337	$ 3,229	1
2	2	Food	Resident Days	1,527,029	77	0	0	17,337	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	17,337	38	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	17,337	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	17,337	321	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	17,337	1,879	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	17,337	757	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	17,337	49	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	17,337	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	17,337	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	17,337	50,953	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	17,337	3,578	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	17,337	886	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	17,337	32,141	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	17,337	231	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	17,337	27	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	17,337	2,892	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	17,337	479	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	17,337	13,116	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	17,337	3,720	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	17,337	4,287	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	17,337	459	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	17,337	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	17,337	443	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 119,485	25

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	389,552	21	$	$	17,337	$	1
2	2	Food	Resident Days	389,552	21			17,337		2
3	3	Housekeeping	Resident Days	389,552	21			17,337		3
4	4	Laundry	Resident Days	389,552	21			17,337		4
5	5	Utilities	Resident Days	389,552	21			17,337		5
6	6	Maintenance	Resident Days	389,552	21			17,337		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21			17,337		7
8	10	Nursing and Medical Records	Resident Days	389,552	21			17,337		8
9	12	Social Services	Resident Days	389,552	21			17,337		9
10	17	Administrative	Resident Days	389,552	21			17,337		10
11	19	Professional Services	Resident Days	389,552	21	17,164		17,337	764	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534		17,337	736	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356		17,337	1,440	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830		17,337	2,796	14
15	23	Inservice Training & Education	Resident Days	389,552	21			17,337		15
16	24	Travel and Seminar	Resident Days	389,552	21			17,337		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21			17,337		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21			17,337		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21			17,337		19
20	30	Depreciation	Resident Days	389,552	21	19,207		17,337	855	20
21	32	Interest	Resident Days	389,552	21	425,239		17,337	18,925	21
22	33	Real Estate Taxes	Resident Days	389,552	21			17,337		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21			17,337		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21			17,337		24
25	TOTALS					$ 573,330	$		$ 25,516	25

Facility Name & ID Number Vandalia Rehabilitation & Health Care Cente # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	01/19/07	$ 657,483	$ 630,103	12/31/13	Varies	$ 31,945	1
2												2
3							Interest Income Offset				(339)	3
4							Home Office Allocation-PHC				4,287	4
5							Home Office Allocation-PHO				18,925	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 657,483	$ 630,103			$ 54,818	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 657,483	$ 630,103			$ 54,818	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** **Line #** **N/A**

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center **#** 0047589 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		$ 35,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 38,253	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,353	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 39,420	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	459	
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.		$ 42,232	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	30,105	8
2006	33,715	9
2007	34,643	10
2008	34,879	11
2009	38,253	12

Accrual based on prior year tax bill.

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Vandalia Rehabilitation & Health Care Center COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0047589

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-14-17-453-012	Long-Term Care Facility	$ 38,253.61	$ 38,253.61
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,253.61	$ 38,253.61

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,764 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	159,430	2005	$ 29,250	1
2					2
3	TOTALS	159,430		$ 29,250	3

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		2005	1969	$ 527,250	$	25	$ 21,090	$ 21,090	$ 115,995	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	13,000		15	867	867	4,768	9
10	Sidewalks			2006	7,967		15	531	531	2,390	10
11	Water Heater			2007	7,681		15	512	512	1,792	11
12	Interior Signage			2007	1,795		10	180	180	630	12
13	Air Conditioner			2007	5,800		15	387	387	1,354	13
14	Carpeting			2007	4,617		10	462	462	1,617	14
15	Electrical Panel Repair			2008	2,600		7	371	371	929	15
16	Heating Unit-Dining Room			2009	3,150		5	630	630	945	16
17	Sprinkler System Repair			2010	5,850		7	418	418	418	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	Land Improvements Booked					1,398			(1,398)		30
31	Building Booked					21,156			(21,156)		31
32	Building Improvement Booked					5,101			(5,101)		32
33											33
34	2010-Home Office Allocation-Building Improvements				8,333			778	778		34
35	2010-Home Office Allocation-Land Improvements				778			200	200		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 Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 588,821	$ 27,655		$ 26,426	$ (1,229)	$ 130,838	70

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 160,902	$ 23,455	$ 21,498	$ (1,957)	7-10 yrs.	$ 108,997	71
72	Current Year Purchases	1,275	182	64	(118)	10 yrs.	64	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,597	3,597			74
75	TOTALS	$ 162,177	$ 23,637	$ 25,159	$ 1,522		$ 109,061	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									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)	$ 780,248	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,292	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 51,585	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 293	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 239,899	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 21,177 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	$ 578	$ 6,360	17
18					18
19					19
20					20
21	TOTAL		$ 578.16	$ 6,360	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.

Vandalia Rehabilitation & Health Care Center
0047589
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 14A

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

Medical Equipment	$	16,079
Dishwasher		708
Maintenance Equipment		32
Copier		3,915
Home Office Allocation		443
		21,177

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

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

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$	8,548	$ 128,225	$	8,548	$ 128,225	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,569	23,533		1,569	23,533	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,983	149,747		9,983	149,747	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				106,795		106,795	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			88	1,320		88	1,320	13
14	TOTAL			$	20,188	$ 302,825	$ 106,795	20,188	$ 409,620	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.

STATE OF ILLINOIS

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 407,512	$ 407,512	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	479,817	479,817	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,281	30,281	6
7	Other Prepaid Expenses	10,381	10,381	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Management Fees	120,000	120,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,047,991	$ 1,047,991	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,217	29,250	13
14	Buildings, at Historical Cost	527,250	535,583	14
15	Leasehold Improvements, at Historical Cost	31,493	53,238	15
16	Equipment, at Historical Cost	162,177	162,177	16
17	Accumulated Depreciation (book methods)	(246,910)	(239,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 524,227	$ 540,349	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,572,218	$ 1,588,340	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 526,194	$ 526,194	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,032	23,032	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,205	13,205	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,420	39,420	32
33	Accrued Interest Payable	2,823	2,823	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	18,265	18,265	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 622,939	$ 622,939	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	630,103	630,103	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 630,103	$ 630,103	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,253,042	$ 1,253,042	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 319,176	$ 335,298	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,572,218	$ 1,588,340	48

*(See instructions.)

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 134,557	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 134,558	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	184,618	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)**	$ 184,618	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)**	$ 319,176	24 *

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,425,167	1
2	Discounts and Allowances for all Levels	(162,398)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,262,769	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	443,278	6
7	Oxygen	1,190	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 444,468	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	4,931	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	180,054	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,889	20
21	Other Medical Services	8,728	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 202,602	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	339	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 339	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	42	28
28a	Transportation Revenue	4,367	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,409	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,914,587	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	526,737	31
32	Health Care	1,225,852	32
33	General Administration	578,895	33
	B. Capital Expense		
34	Ownership	152,965	34
	C. Ancillary Expense		
35	Special Cost Centers	182,010	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,729,969	40
41	**Income before Income Taxes (line 30 minus line 40)****	184,618	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 184,618	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.**

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 53,950	$ 25.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,194	2,237	50,867	22.74	3
4	Licensed Practical Nurses	16,402	17,041	282,426	16.57	4
5	CNAs & Orderlies	37,181	38,359	347,654	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,988	2,073	21,703	10.47	9
10	Activity Assistants	399	399	3,348	8.39	10
11	Social Service Workers	1,935	2,141	23,306	10.89	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,224	11.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,051	11,481	95,556	8.32	15
16	Dishwashers					16
17	Maintenance Workers	2,085	2,142	35,646	16.64	17
18	Housekeepers	7,953	8,299	69,493	8.37	18
19	Laundry	5,078	5,085	41,733	8.21	19
20	Administrator	2,080	2,080	48,750	23.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,045	2,133	41,565	19.49	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 C: Care Plan Coord.	1,887	1,912	34,500	18.04	32
33	Other(specify) Transportation	1,286	1,286	12,698	9.87	33
34	TOTAL (lines 1 - 33)	97,724	100,828	$ 1,186,419 *	$ 11.77	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	9,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,939	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 12,539		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Vaughan	Administrator	0	$ 48,750
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,750

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 201,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 201,000

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	3,660
AT&T	Computer Services	520
Burnside, Johnston	Legal Services	223
Heyl, Royster, Voelker & Allen	Legal Services	248
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,651

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,728
Unemployment Compensation Insurance	24,010
FICA Taxes	85,965
Employee Health Insurance	84,252
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,409
Employee Retirement	670
Life Insurance	318
TOTAL (agree to Schedule V, line 22, col.8)	$ 261,352

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	$ 1,990
Advertising: Employee Recruitment	482
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 121	1,212
Miscellaneous Licenses & Permits	1,278
Miscellaneous Dues & Subscriptions	658
IHCA Dues	1,600
Home Office Allocation	1,622
Less: Public Relations Expense	(658)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,184

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	27
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27

**See instructions.

Vandalia Rehabilitation & Health Care Center
0047589
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		4,651
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	3
Healthcare Resources International	Legal	44
Ginoli & Company	Accountants	1,397
Bank of America	Accountants	139
Miscellaneous Vendors	Computer Services	19
VisionShare	Computer Services	191
Advanced Answers on Demand	Computer Services	1,196
Access 2 Go	Computer Services	194
Kemper Technology	Computer Services	165
MediFax	Computer Services	68
Logmeln	Computer Services	49
Simple LTC	Computer Services	763
Optimizer Systems	Other Professional I	28
Clifton Gunderson	Other Professional I	86
Total (agree to Schedule V, line 19, column 8)		8,993

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **1,600 IHCA**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,105** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **63,510**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,367**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,356**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.