

		FOR OHF USE					

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**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)**

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

<p>I. IDPH Facility ID Number: <u>0037309</u></p> <p>Facility Name: <u>VANDALIA TERRACE</u></p> <p>Address: <u>1610 HILLSBORO ROAD</u> <u>VANDALIA</u> <u>62471</u> <small>Number City Zip Code</small></p> <p>County: <u>FAYETTE</u></p> <p>Telephone Number: <u>(618) 283-1434</u> Fax # <u>(618) 283-2174</u></p> <p>IDPA ID Number: <u>37-1282320</u></p> <p>Date of Initial License for Current Owners: <u>08/01/91</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MELVIN SIEGEL</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MELVIN SIEGEL</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	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	
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Facility Name & ID Number VANDALIA TERRACE

0037309 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	79	Intermediate (ICF)	79	28,835	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	17,163	579		17,742
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	17,163	579		17,742

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.53%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/91 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **VANDALIA TERRACE** # **0037309** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	76,529	5,082	3,936	85,547		85,547		85,547		1
2	Food Purchase		60,337		60,337		60,337	(314)	60,023		2
3	Housekeeping	23,985	5,008		28,993		28,993		28,993		3
4	Laundry	17,289	2,876		20,165		20,165		20,165		4
5	Heat and Other Utilities			58,067	58,067		58,067	1,436	59,503		5
6	Maintenance	27,165		22,664	49,829		49,829	(456)	49,373		6
7	Other (specify):*			2,214	2,214		2,214	199	2,413		7
8	TOTAL General Services	144,968	73,303	86,881	305,152		305,152	865	306,017		8
	B. Health Care and Programs										
9	Medical Director			8,701	8,701		8,701		8,701		9
10	Nursing and Medical Records	361,204	12,822	5,436	379,462		379,462	6,878	386,340		10
10a	Therapy										10a
11	Activities	15,104	1,877	3,732	20,713		20,713	(2,340)	18,373		11
12	Social Services	17,893	1,496		19,389		19,389		19,389		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	394,201	16,195	17,869	428,265		428,265	4,538	432,803		16
	C. General Administration										
17	Administrative	48,880		3,000	51,880		51,880	1,836	53,716		17
18	Directors Fees										18
19	Professional Services			90,467	90,467		90,467	(73,251)	17,216		19
20	Dues, Fees, Subscriptions & Promotions			7,389	7,389		7,389	(523)	6,866		20
21	Clerical & General Office Expenses	24,908	5,447	19,926	50,281		50,281	22,679	72,960		21
22	Employee Benefits & Payroll Taxes			130,551	130,551		130,551		130,551		22
23	Inservice Training & Education							184	184		23
24	Travel and Seminar			134	134		134	5,566	5,700		24
25	Other Admin. Staff Transportation			4,977	4,977		4,977	3,522	8,499		25
26	Insurance-Prop.Liab.Malpractice			74,160	74,160		74,160	1,067	75,227		26
27	Other (specify):*			5,151	5,151		5,151	12,528	17,679		27
28	TOTAL General Administration	73,788	5,447	335,755	414,990		414,990	(26,392)	388,598		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	612,957	94,945	440,505	1,148,407		1,148,407	(20,989)	1,127,418		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	3,936
	REPAIRS & MAINTENANCE		0
			0
			3,936
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		24,464
	ELECTRICITY		16,016
	WATER		15,780
	CABLE TV - LOBBY		1,807
			0
			58,067
6	MAINTENANCE		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE CONSULTANT		6,660
	EQUIPMENT MAINTENANCE & REPAIR		13,847
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		605
	FIRE SERVICE		1,552
			0
			0
			0
			22,664
7	OTHER		
	SCAVENGER		2,214
	SECURITY SERVICE		0
			2,214
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,701
			8,701

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	2,340
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	846
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	GERIATRIC CONSULTANT	XVIII B 48-2	2,250
			0
			5,436
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,732
			0
			3,732
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	3,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,921
	ADMINISTRATIVE CONSULTANTS XIX C	4,632
	PROFESSIONAL FEES XIX C	9,801
	BOOKKEEPING /ADMINISTRATIVE SERVICES	68,113
20	FEES,SUBSCRIPTIONS,PROMOTIONS	90,467
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	206
	EMPLOYEE WANT ADS XIX F	522
	CONTRIBUTIONS VI 20 XIX F	200
	DUES & SUBSCRIPTIONS XIX F	4,073
	LICENSES & PERMITS XIX F	2,090
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	298
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	CLERICAL & GENERAL OFFICE EXPENSES	7,389
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,955
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	10,157
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	7,814
	MESSENGER SERVICE	0
		0
		19,926

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	46,822
	UNEMPLOYMENT COMPENSATION XIX D	25,928
	WORKERS COMPENSATION INSURANCE XIX D	24,036
	HOSPITALIZATION INSURANCE XIX D	32,153
	EMPLOYEE BENEFITS - OTHER XIX D	1,612
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		130,551
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	134
	TRAVEL XIX G	0
		0
		0
		134
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,977
		4,977
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	74,160
		74,160
27	OTHER	
	BAD DEBTS VI 24	5,151
		5,151

GRAND TOTAL COLUMN 3 OTHER 440,505

VANDALIA TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	60,337	PATIENT MEALS	53226
LESS SALES TAX	(314)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	60,023	TOTAL MEALS/YEAR	53226
TOTAL PATIENT CENSUS	17,742	NET FOOD	60023
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	53226

TOTAL PATIENT MEALS	53226	COST PER MEAL	1.13
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,267	4,267		4,267	13,707	17,974			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							48,594	48,594			32
33	Real Estate Taxes			25,058	25,058		25,058		25,058			33
34	Rent-Facility & Grounds			44,508	44,508		44,508	(38,205)	6,303			34
35	Rent-Equipment & Vehicles			4,998	4,998		4,998	3,454	8,452			35
36	Other (specify):*											36
37	TOTAL Ownership			78,831	78,831		78,831	27,550	106,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,253	43,253		43,253		43,253			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			43,253	43,253		43,253		43,253			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	612,957	94,945	562,589	1,270,491		1,270,491	6,561	1,277,052			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 TERRACE**

0037309

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,131	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(314)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,157)	21		18
19	Entertainment		20		19
20	Contributions	(498)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,151)	27		24
25	Fund Raising, Advertising and Promotional	(206)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,195)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	22,756		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,756		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 6,561		37

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

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

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

VANDALIA TERRACE

ID# 0037309

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VANDALIA TERRACE

0037309

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(314)	0	0	0	0	0	0	0	0	0	0	(314)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,436	0	0	0	0	0	0	0	0	0	1,436	5
6	Maintenance	0	(456)	0	0	0	0	0	0	0	0	0	(456)	6
7	Other (specify):*	0	199	0	0	0	0	0	0	0	0	0	199	7
8	TOTAL General Services	(314)	1,179	0	0	0	0	0	0	0	0	0	865	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,878	0	0	0	0	0	0	0	0	0	6,878	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(2,340)	0	0	0	0	0	0	0	0	0	(2,340)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	4,538	0	0	0	0	0	0	0	0	0	4,538	16
	C. General Administration													
17	Administrative	0	1,836	0	0	0	0	0	0	0	0	0	1,836	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,000)	(72,251)	0	0	0	0	0	0	0	0	0	(73,251)	19
20	Fees, Subscriptions & Promotions	(704)	0	181	0	0	0	0	0	0	0	0	(523)	20
21	Clerical & General Office Expenses	(10,157)	0	32,836	0	0	0	0	0	0	0	0	22,679	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	184	0	0	0	0	0	0	0	0	184	23
24	Travel and Seminar	0	0	5,566	0	0	0	0	0	0	0	0	5,566	24
25	Other Admin. Staff Transportation	0	0	3,522	0	0	0	0	0	0	0	0	3,522	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,067	0	0	0	0	0	0	0	0	1,067	26
27	Other (specify):*	(5,151)	0	17,679	0	0	0	0	0	0	0	0	12,528	27
28	TOTAL General Administration	(17,012)	(70,415)	61,035	0	(26,392)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,326)	(64,698)	61,035	0	(20,989)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VANDALIA TERRACE

0037309

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,131	0	291	12,285	0	0	0	0	0	0	0	13,707	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	831	47,763	0	0	0	0	0	0	0	48,594	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,303	(44,508)	0	0	0	0	0	0	0	(38,205)	34
35	Rent-Equipment & Vehicles	0	0	3,454	0	0	0	0	0	0	0	0	3,454	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,131	0	10,879	15,540	0	27,550	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,195)	(64,698)	71,914	15,540	0	6,561	45						

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
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD.		BOOKKEEPING
		RIVER VIEW MANOR	LOVES PARK			
SEE ATTACHED SCHEDULE		PARKVIEW TERRACE	EAST MOLINE	MEVIN NURSING	SKOKIE, IL	REAL ESTATE
		GOLDEN TERRACE	JACKSONVILLE	ASSOC LTD		
		SPRINGFIELD TERRACE	SPRINGFIELD			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 MAINTENANCE CONSULTANT	\$ 6,660	MAVIN ENTERPRISES, LTD		\$	\$ (6,660)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	2,340				(2,340)	2
3	V	11 ACTIVITIES CONSULTANT	2,340				(2,340)	3
4	V	19 ADMIN. /BKKP. FEES	68,073				(68,073)	4
5	V	19 ADMIN. /CONSULT. FEES	4,632				(4,632)	5
6	V							6
7	V	5 ELECTRICITY/GAS				1,436	1,436	7
8	V	6 MAINTENANCE SALARIES				6,188	6,188	8
9	V	6 MAINTENANCE & REPAIR				16	16	9
10	V	7 SCAVENGER				199	199	10
11	V	10 PSYCHO-SOCIAL & NURSING CONSULT				9,218	9,218	11
12	V	17 ADMINISTRATIVE SALARIES				1,836	1,836	12
13	V	19 PROFESSIONAL FEES				454	454	13
14	Total		\$ 84,045			\$ 19,347	\$ * (64,698)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 ADVERTISING	\$	MAVIN ENTERPRISES, LTD.		\$ 181	\$	181	15
16	V	21 TOTAL OFFICE				32,836		32,836	16
17	V	23 SEMINARS				184		184	17
18	V	24 TRAVEL				5,566		5,566	18
19	V	25 TRANSPORTATION				3,522		3,522	19
20	V	26 INSURANCE				1,067		1,067	20
21	V	27 EMPLOYEE BENEFITS				17,679		17,679	21
22	V	30 DEPRECIATION (SL)				291		291	22
23	V	32 INTEREST				831		831	23
24	V	34 OFFICE RENT				6,303		6,303	24
25	V	35 EQUIPMENT RENT				3,454		3,454	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		\$			\$ 71,914	\$ *	71,914	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$ 44,508	MAVIN NURSING ASSOC. LTD. PARTNERSHIP		\$	(44,508)	15
16	V	30 DEPRECIATION				12,285	12,285	16
17	V	32 INTEREST				47,763	47,763	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$ 44,508			\$ 60,048	\$ * 15,540	39

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

Facility Name & ID Number

VANDALIA TERRACE

#

0037309

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6		SEE ATTACHED SCHEDULE									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 **VANDALIA TERRACE**

0037309

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization MAVIN ENTERPRISES, LTD.
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-0100
 Fax Number (847) 679-0647

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	143,350	7	\$ 11,595	\$ 17,742	\$ 1,436	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	143,350	7	50,000	17,742	6,188	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	143,350	7	128	17,742	16	3
4	7	SCAVENGER	PATIENT DAYS	143,350	7	1,602	17,742	199	4
5	10	PSYCHO-SOCIAL & NURSING	PATIENT DAYS	143,350	7	74,480	17,742	9,218	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	143,350	7	14,850	17,742	1,836	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	143,350	7	3,665	17,742	454	7
8	20	ADVERTISING	PATIENT DAYS	143,350	7	1,451	17,742	181	8
9	21	TOTAL OFFICE	PATIENT DAYS	143,350	7	265,310	17,742	32,836	9
10	23	SEMINARS	PATIENT DAYS	143,350	7	1,485	17,742	184	10
11	24	TRAVEL	PATIENT DAYS	143,350	7	44,974	17,742	5,566	11
12	25	TRANSPORTATION	PATIENT DAYS	143,350	7	28,456	17,742	3,522	12
13	26	INSURANCE	PATIENT DAYS	143,350	7	8,617	17,742	1,067	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	143,350	7	142,843	17,742	17,679	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	143,350	7	2,332	17,742	291	15
16	32	INTEREST	PATIENT DAYS	143,350	7	6,726	17,742	831	16
17	34	OFFICE RENT	PATIENT DAYS	143,350	7	50,915	17,742	6,303	17
18	35	EQUIPMENT RENT	PATIENT DAYS	143,350	7	27,901	17,742	3,454	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 737,330	\$ 283,533	\$ 91,261	25

Facility Name & ID Number

VANDALIA TERRACE

0037309

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	RELATED PARTY						\$	\$			\$	1						
2	MAVIN NURSING ASSOC											2						
3	BANK FINANCIAL		X	MORTGAGE	\$5,896.00	10/04/01	650,000	615,339	09/28/06	6.1500	47,673	3						
4												4						
5	MGMT ALLOCATION										831	5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$5,896.00		\$ 650,000	\$ 615,339			\$ 48,504	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 650,000	\$ 615,339			\$ 48,504	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2004 report.		\$	21,156	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.)		\$	22,992	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,836	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	23,222	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	25,058	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	18,199	8
	2001	19,630	9
	2002	20,772	10
	2003	20,947	11
	2004	22,992	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME VANDALIA TERRACE COUNTY FAYETTE

FACILITY IDPH LICENSE NUMBER 0037309

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-14-08-180-002</u>	<u>NURSING HOME</u>	\$ <u>22,992.44</u>	\$ <u>22,992.44</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>22,992.44</u>	\$ <u>22,992.44</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number VANDALIA TERRACE

0037309

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **VANDALIA TERRACE**

0037309

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	79	1991		\$ 386,952	\$ 12,285	31.5	\$ 12,285	\$	\$ 166,763	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS	1991		17,600	559	20	880	321	11,748	9
10	VARIOUS	1992		992		20			992	10
11	VARIOUS	1993		4,216	108	20	211	103	2,619	11
12	VARIOUS	1994		15,024	385	20	751	366	8,424	12
13	VARIOUS	1995		2,096	54	20	105	51	1,091	13
14	ROOF REPAIRS	1996		2,450	63	20	123	60	1,230	14
15	ROOF REPAIRS	1996		4,120	106	20	206	100	2,060	15
16	ROOF REPAIRS	1996		4,295	110	20	215	105	2,078	16
17	INSTALLED NEW DURO-LAST ROOF	2000		54,300	1,975	27.5	1,975		10,863	17
18	INSTALLED NEW CARPETING IN FRONT LOBBY	2000		665		20	33	33	198	18
19	INSTALL A DOOR ACCESS SYSTEM	2001		11,503	418	27.5	418		1,881	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								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)	\$ 504,213	\$ 16,063		\$ 17,202	\$ 1,139	\$ 209,947	70

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

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	\$ 30,488	\$ 489	\$ 481	\$ (8)	8-10 YRS	\$ 27,586	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	MGMT ALLOCATION		291	291				74
75	TOTALS	\$ 30,488	\$ 780	\$ 772	\$ (8)		\$ 27,586	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	FACILTY	1991 DODGE CARAVAN	1991	\$ 19,088	\$	\$	\$		\$ 19,088	76
77										77
78										78
79										79
80	TOTALS			\$ 19,088	\$	\$	\$		\$ 19,088	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)	\$ 553,789	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,843	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,974	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,131	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 256,621	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					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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A - RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **4,998** Description: **SEE SCHEDULE ATTACHED**

(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			\$	\$ 0	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 VANDALIA TERRACE

0037309

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,089	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	316,667		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,845		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	329,937		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 669,538	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	116,596		15
16	Equipment, at Historical Cost	49,576		16
17	Accumulated Depreciation (book methods)	(79,941)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	15,111		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 101,342	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 770,880	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 182,743	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	489,315		29
30	Accrued Salaries Payable	24,551		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,001		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,222		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 789,832	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,801		39
40	Mortgage Payable			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)	\$ 32,801	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 822,633	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (51,753)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 770,880	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (181,789)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(965)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (182,754)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	131,001	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)	\$ 131,001	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)	\$ (51,753)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,401,492	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,401,492	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,401,492	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	305,152	31
32	Health Care	428,265	32
33	General Administration	414,990	33
	B. Capital Expense		
34	Ownership	78,831	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,253	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,270,491	40
41	Income before Income Taxes (line 30 minus line 40)**	131,001	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 131,001	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.

*** 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 TERRACE

0037309

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,759	1,871	\$ 35,175	\$ 18.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	624	648	13,113	20.24	3
4	Licensed Practical Nurses	9,845	10,413	155,477	14.93	4
5	CNAs & Orderlies	14,308	14,928	119,657	8.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,714	1,826	15,104	8.27	10
11	Social Service Workers	1,789	1,886	17,893	9.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,171	9,820	76,529	7.79	15
16	Dishwashers					16
17	Maintenance Workers	1,888	2,080	27,165	13.06	17
18	Housekeepers	3,489	3,729	23,985	6.43	18
19	Laundry	2,018	2,162	17,289	8.00	19
20	Administrator	1,968	2,080	48,880	23.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,616	1,792	24,908	13.90	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: <u>Care Plan Coord</u>	1,952	2,164	37,782	17.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	52,141	55,399	\$ 612,957 *	\$ 11.06	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 3,936	1-3	35
36	Medical Director	O	8,701	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	846	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,732	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>	S	2,340	10-3	47
48	<u>GERIATRIC CONSULTANT</u>		2,250	10-3	48
49	TOTAL (lines 35 - 48)		\$ 21,805		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **VANDALIA TERRACE**

0037309

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
BYRON WITT	ADMIN		\$ 48,880	Workers' Compensation Insurance	\$ 24,036	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	25,928	Advertising: Employee Recruitment	522	
				FICA Taxes	46,822	Health Care Worker Background Check	0	
				Employee Health Insurance	32,153	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	206	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	498	
				EMPLOYEE BENEFITS - OTHER	1,612	LICENSES & PERMITS	100	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	4,073	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	181	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(498)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(206)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,880	TOTAL (agree to Schedule V, line 22, col.8)	\$ 130,551	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,866	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MELVIN SIEGEL	MANAGEMENT FEES		\$ 3,000				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,000				MGMT ALLOCATION	5,566
							Seminar Expense	134
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
GARY A. WEINTRAUB	LEGAL FEES		\$ 3,463	TOTAL		\$	TOTAL	\$ 5,700
KRUPNICK, BOKOR, KAGDA	ACCOUNTING FEES		4,250					
PERSONNEL PLANNERS	U.C. CONSULTANT		1,088					
LTC SOLUTIONS, INC.	DATA PROCESSING		1,320					
ALPHA DATA SERVICES	DATA PROCESSING		1,785					
BKD TECHNOLOGIES	DATA PROCESSING		422					
NURSING CARE SYSTEMS	DATA PROCESSING		4,394					
MAVIN ENTERPRISES LTD	BOOKKEEPING/ADMIN		68,073					
SAK MANAGEMENT SERVICES	BOOKKEEPING/ADMIN		40					
MAVIN ENTERPRISES LTD	ADMIN. CONSULTANT		4,632					
GENSON & GILLESPIE	LEGAL FEES		1,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 90,467					

* Attach copy of IMRF notifications

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9						N/A														
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$	\$	\$	\$	\$ 0	\$	\$	\$	\$	\$								

Facility Name & ID Number VANDALIA TERRACE

0037309

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$3,960
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (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. _____
- (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. \$ 43,253
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? _____ Indicate the amount. \$ _____
- (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? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
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? NO**
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? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees