



Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

# 0047589 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	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	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,805</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>59</u>	Intermediate (ICF)	<u>59</u>	<u>21,535</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>116</u>	TOTALS	<u>116</u>	<u>42,340</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>2,196</u>	<u>2,196</u>	8
9	SNF/PED					9
10	ICF	<u>12,133</u>	<u>2,517</u>	<u>79</u>	<u>14,729</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,133</u>	<u>2,517</u>	<u>2,275</u>	<u>16,925</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.97%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 57 and days of care provided 2,196

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center # 0047589 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	115,107	10,122		125,229		125,229	2,960	128,189		1
2	Food Purchase		96,671		96,671		96,671	(4,838)	91,833		2
3	Housekeeping	60,001	13,074		73,075		73,075	28	73,103		3
4	Laundry	39,282	9,306		48,588		48,588		48,588		4
5	Heat and Other Utilities			75,259	75,259		75,259	292	75,551		5
6	Maintenance	38,170	11,694	24,875	74,739		74,739	3,092	77,831		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							534	534		7
8	<b>TOTAL General Services</b>	252,560	140,867	100,134	493,561		493,561	2,068	495,629		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	775,812	72,379	3,522	851,713		851,713	1,593	853,306		10
10a	Therapy		35	289,951	289,986		289,986		289,986		10a
11	Activities	26,550	312	373	27,235		27,235		27,235		11
12	Social Services	20,885			20,885		20,885		20,885		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							221	221		15
16	<b>TOTAL Health Care and Programs</b>	823,247	72,726	303,446	1,199,419		1,199,419	1,814	1,201,233		16
	<b>C. General Administration</b>										
17	Administrative	28,000		198,000	226,000		226,000	(164,305)	61,695		17
18	Directors Fees										18
19	Professional Services			16,013	16,013		16,013	5,305	21,318		19
20	Dues, Fees, Subscriptions & Promotions			5,522	5,522		5,522	1,704	7,226		20
21	Clerical & General Office Expenses	40,413	6,200	12,626	59,239		59,239	32,678	91,917		21
22	Employee Benefits & Payroll Taxes			194,510	194,510		194,510		194,510		22
23	Inservice Training & Education			(325)	(325)		(325)	308	(17)		23
24	Travel and Seminar							95	95		24
25	Other Admin. Staff Transportation			9,538	9,538		9,538	1,785	11,323		25
26	Insurance-Prop.Liab.Malpractice			38,363	38,363		38,363	617	38,980		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							11,664	11,664		27
28	<b>TOTAL General Administration</b>	68,413	6,200	474,247	548,860		548,860	(110,149)	438,711		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,144,220	219,793	877,827	2,241,840		2,241,840	(106,267)	2,135,573		29

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			50,622	50,622		50,622	(703)	49,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,737	32,737		32,737	18,938	51,675			32
33	Real Estate Taxes			34,779	34,779		34,779	375	35,154			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,703	28,703		28,703	359	29,062			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			146,841	146,841		146,841	18,969	165,810			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,101		92,101		92,101		92,101			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):* <b>Non-allowable Cost</b>		333	103,873	104,206		104,206	(104,206)				43
44	<b>TOTAL Special Cost Centers</b>		92,434	167,383	259,817		259,817	(104,206)	155,611			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,144,220	312,227	1,192,051	2,648,498		2,648,498	(191,504)	2,456,994			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(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	(4,173)	30		9
10	Interest and Other Investment Income	(3,563)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(307)	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	(262)	43		18
19	Entertainment				19
20	Contributions	(600)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,114)	43		24
25	Fund Raising, Advertising and Promotional	(2,589)	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 Pg. 5A	(27,903)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (117,799)		\$	30

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(73,705)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (73,705)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (191,504)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52	
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Vandalia Rehabilitation & Health Care Center

ID# 0047589

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (6,550)	43	1
2	X-Rays-Part A	(15,178)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(198)	10	3
4	Offset Miscellaneous Food Revenue	(4,904)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(99)	21	5
6	Resident Flowers	(243)	43	6
7	Disallowed Special Events	(75)	43	7
8	Disallowed Dues	(656)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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45				45
46				46
47				47
48				48
49	<b>Total</b>	(27,903)		49

**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 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.**  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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,960	\$ 2,960	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	66	66	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	28	28	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	292	292	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,434	1,434	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	534	534	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,791	1,791	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	221	221	10
11	V	17 Administrative	198,000	Petersen Health Care, Inc.	100.00%	33,695	(164,305)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,150	4,150	12
13	V							13
14	Total		\$ 198,000			\$ 45,171	\$ * (152,829)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,157	\$	1,157	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	30,181		30,181	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	308		308	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	95		95	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,487		1,487	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	617		617	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,101		8,101	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,439		2,439	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,752		3,752	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	375		375	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	359		359	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	<b>Total</b>		\$			\$ 48,871	\$ *	48,871	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,658	1,658	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,155	1,155	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	1,203	1,203	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,596	2,596	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	298	298	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%	3,563	3,563	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,031	1,031	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	18,749	18,749	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	<b>Total</b>		\$			\$ 30,253	\$ *	30,253	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: 1/1/2009 Ending: 12/31/2009

## 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	Mark Petersen	President	Administrative	100.00	157,189	0.66	1.10	Salary	\$ 1,924	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,924		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: 1/1/2009 Ending: 2/31/2009

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 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	16,925	\$ 2,960	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	16,925	66	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	16,925	28	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	16,925	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	16,925	292	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	16,925	1,434	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	16,925	534	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	16,925	1,791	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	16,925	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	16,925	221	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	16,925	33,695	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	16,925	4,150	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	16,925	1,157	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	16,925	30,181	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	16,925	308	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	16,925	95	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	16,925	1,487	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	16,925	617	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	16,925	8,101	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	16,925	2,439	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	16,925	3,752	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	16,925	375	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	16,925	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	16,925	359	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 94,042	25

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

# 0047589

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	399,145	21	\$	\$	16,925	\$	1
2	2	Food	Resident Days	399,145	21			16,925		2
3	3	Housekeeping	Resident Days	399,145	21			16,925		3
4	4	Laundry	Resident Days	399,145	21			16,925		4
5	5	Utilities	Resident Days	399,145	21			16,925		5
6	6	Maintenance	Resident Days	399,145	21	39,101		16,925	1,658	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21			16,925		7
8	10	Nursing and Medical Records	Resident Days	399,145	21			16,925		8
9	12	Social Services	Resident Days	399,145	21			16,925		9
10	17	Administrative	Resident Days	399,145	21			16,925		10
11	19	Professional Services	Resident Days	399,145	21	27,247		16,925	1,155	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366		16,925	1,203	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225		16,925	2,596	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21			16,925		14
15	23	Inservice Training & Education	Resident Days	399,145	21			16,925		15
16	24	Travel and Seminar	Resident Days	399,145	21			16,925		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018		16,925	298	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21			16,925		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024		16,925	3,563	19
20	30	Depreciation	Resident Days	399,145	21	24,325		16,925	1,031	20
21	32	Interest	Resident Days	399,145	21	442,158		16,925	18,749	21
22	33	Real Estate Taxes	Resident Days	399,145	21			16,925		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21			16,925		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21			16,925		24
25	TOTALS					\$ 713,464	\$		\$ 30,253	25

Facility Name & ID Number Vandalia Rehabilitation & Health Care Cente # 0047589 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		X	Mortgage	Varies	01/19/07	\$ 657,483	\$ 637,750	12/31/13	Varies	\$ 32,737	1							
2												2							
3							Interest Income Offset				(3,563)	3							
4							Home Office Allocation-PHC				3,752	4							
5							Home Office Allocation-PHO				18,749	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 657,483	\$ 637,750			\$ 51,675	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 657,483	\$ 637,750			\$ 51,675	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:

1/1/2009

Ending:

12/31/2009

**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?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>159,430</u>	<u>2005</u>	<u>\$ 29,250</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>159,430</b>		<b>\$ 29,250</b>	<b>3</b>

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	116	2005	1969	\$ 527,250	\$	25	\$ 21,090	\$ 21,090	\$ 94,905
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Original Land Improvements	2005		13,000		15	867	867	3,901
10	Sidewalks	2006		7,967		15	531	531	1,859
11	Water Heater	2007		7,681		15	512	512	1,280
12	Interior Signage	2007		1,795		10	180	180	450
13	Air Conditioner	2007		5,800		15	387	387	967
14	Carpeting	2007		4,617		10	462	462	1,155
15	Electrical Panel Repair	2008		2,600		7	372	372	558
16	Heating Unit-Dining Room	2009		3,150		5	315	315	315
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				1,398			(1,398)	
28	Building Booked				21,155			(21,155)	
29	Building Improvement Booked				4,614			(4,614)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			557			35	35	
33	2009-Home Office Allocation-Building Improvements			8,320			200	200	
34									
35									
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)		\$ 582,737	\$ 27,167		\$ 24,951	\$ (2,216)	\$ 105,390	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	\$ 160,902	\$ 23,455	\$ 21,498	\$ (1,957)	7-10 yrs.	\$ 87,499	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,470	3,470			74
75	TOTALS	\$ 160,902	\$ 23,455	\$ 24,968	\$ 1,513		\$ 87,499	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										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)	\$ 772,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,622	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,919	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (703)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 192,889	85

\*\*

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 22,124 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	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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  
0047583**

**Period Beginning 1/1/2009  
Period End 12/31/2009**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 18,146
Dishwasher	693
Maintenance Equipment	48
Copier	2,878
Home Office Allocation	359
	<u>22,124</u>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	10A(3)	hrs	\$	8,970	\$ 134,549	\$	8,970	\$ 134,549	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,286	19,289		1,286	19,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,009	135,133	35	9,009	135,168	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				92,101		92,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			65	980		65	980	13
14	TOTAL			\$	19,330	\$ 289,951	\$ 92,136	19,330	\$ 382,087	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 Rehabilitation & Health Care Center**# **0047589**Report Period Beginning: **1/1/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 236,507	\$ 236,507	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u> )	495,718	495,718	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,825	57,825	6
7	Other Prepaid Expenses	10,381	10,381	7
8	Accounts Receivable (owners or related parties)	35,000	35,000	8
9	Other(specify): <u>Employee Education Loans</u>	117	117	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 835,548	\$ 835,548	10
<b>B. Long-Term Assets</b>				
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	535,570	14
15	Leasehold Improvements, at Historical Cost	25,643	47,167	15
16	Equipment, at Historical Cost	160,901	160,902	16
17	Accumulated Depreciation (book methods)	(195,620)	(192,889)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 568,391	\$ 580,000	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,403,939	\$ 1,415,548	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 509,394	\$ 509,394	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)	3,153	3,153	31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,900	35,900	32
33	Accrued Interest Payable	2,854	2,854	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	57,299	57,299	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 631,632	\$ 631,632	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	637,750	637,750	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 637,750	\$ 637,750	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,269,382	\$ 1,269,382	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 134,557	\$ 146,166	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,403,939	\$ 1,415,548	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>108,738</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2008 Bad Debt Allowance Entered After CR Completion</b>	<b>(20,000)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>88,738</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>45,819</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>45,819</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>134,557</b>	<b>24</b> *

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

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center# 0047589Report Period Beginning: 1/1/2009Ending: 12/31/2009**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,094,062	1
2	Discounts and Allowances for all Levels	2,322	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,096,384	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	423,978	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 423,978	8
<b>C. Other Operating Revenue</b>			
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	4,904	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,445	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,979	20
21	Other Medical Services	4,767	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 170,095	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,563	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,563	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	297	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 297	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,694,317	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	493,561	31
32	Health Care	1,199,419	32
33	General Administration	548,860	33
<b>B. Capital Expense</b>			
34	Ownership	146,841	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	196,307	35
36	Provider Participation Fee	63,510	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,648,498	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	45,819	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 45,819	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:

**1/1/2009**

Ending:

**12/31/2009**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,131	2,240	\$ 55,770	\$ 24.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,295	2,346	51,880	22.11	3
4	Licensed Practical Nurses	17,052	17,350	286,897	16.54	4
5	CNAs & Orderlies	38,024	38,902	342,212	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,980	1,988	20,218	10.17	9
10	Activity Assistants	560	560	4,474	7.99	10
11	Social Service Workers	1798	1,969	20,885	10.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,881	11.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,140	11,479	92,226	8.03	15
16	Dishwashers					16
17	Maintenance Workers	2,820	2,827	38,170	13.50	17
18	Housekeepers	7,380	7,592	60,001	7.90	18
19	Laundry	4,790	4,952	39,282	7.93	19
20	Administrator	2,600	2,600	59,771	22.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,039	2,150	40,413	18.80	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Marketing	198	198	1,858	9.38	32
33	Other(specify) Care Plan Coord.	2,016	2,103	39,053	18.57	33
34	TOTAL (lines 1 - 33)	98,903	101,336	\$ 1,175,991 *	\$ 11.60	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 9,600	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	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)	\$ 10,800		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

**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	
Shannon Paden	Administrator	0	\$ 18,000	Workers' Compensation Insurance	\$ 56,344	IDPH License Fee	\$	
Michelle Vaughan	Administrator	0	41,771	Unemployment Compensation Insurance	26,736	Advertising: Employee Recruitment	1,356	
				FICA Taxes	86,474	Health Care Worker Background Check		
				Employee Health Insurance	23,463	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	181	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	200	
				Employee Relations	1,344	Miscellaneous Dues & Subscriptions	656	
				Employee Retirement	149	IHCA Dues	1,500	
						Home Office Allocation	2,360	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	(656)	
(List each licensed administrator separately.)			\$ 59,771			Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 198,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 198,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description			Description	
				Line #			Amount	
<b>C. Professional Services</b>				Amount			Amount	
Vendor/Payee	Type		Amount				Out-of-State Travel	
SimpleLTC, Inc.	Computer Services		\$ 81				\$	
E-Health Data Solutions	Computer Services		2,940					
AT&T	Computer Services		480					
LTC Solutions	Computer Services		1,700	N/A			In-State Travel	
Heyl, Royster, Voelker & Allen	Legal Services		5,782					
Shawnee Communications	Computer Services		30					
Clifton Gunderson LLP	Accounting Services		5,000				Seminar Expense	
							Home Office Allocation	
							95	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 16,013				(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 95	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Vandalia Rehabilitation & Health Care Center**

**0047589**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		16,013
<b>Home Office Allocation</b>		
Heyl, Royster, Voelker & Allen	Legal	(12)
GoffWilson, P.A.	Legal	38
Jackson Lewis	Legal	294
Peter Gartelos	Legal	29
Misc.	Legal	26
Ginoli & Company	Accountants	1,790
Miscellaneous Vendors	Computer Services	28
Emdeon Business Services	Computer Services	13
Advanced Answers on Demand	Computer Services	1,594
Access 2 Go	Computer Services	153
Ivans	Computer Services	83
Kemper Technology	Computer Services	433
VisionShare	Computer Services	135
MediFax	Computer Services	55
LogmeIn	Computer Services	24
Charter Communications	Computer Services	1
Simple LTC	Computer Services	368
Miscellaneous Vendors	Miscellaneous	253
Total (agree to Schedule V, line 19, column 8)		<u>21,318</u>

**Vandalia Rehabilitation & Health Care Center**

**0047589**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21B**

**XIX. SUPPORT SCHEDULE**

**Legal Fees**

**Facility**

<b>Vendor/Payee</b>	<b>Invoice Total</b>	<b>Allocation %</b>	<b>Total</b>
Heyl, Royster, Voelker, and Allen	69.00	100%	69
Heyl, Royster, Voelker, and Allen	2,399.21	100%	2,399
Heyl, Royster, Voelker, and Allen	451.60	100%	452
Heyl, Royster, Voelker, and Allen	69.00	100%	69
Heyl, Royster, Voelker, and Allen	2,005.58	100%	2,006
Heyl, Royster, Voelker, and Allen	787.22	100%	787

**Home Office Allocation**

Heyl, Royster, Voelker, and Allen	2,414.77	1.10%	27
GoffWilson	3,425.00	1.10%	38
Jackson Lewis	27,043.20	1.10%	294
Peter Gartelos	2,612.50	1.10%	29
Miscellaneous Vendors	2,327.62	1.10%	26

**Management Company Allocation**

Heyl, Royster, Voelker, and Allen	(927.00)	4.25%	(39)
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**Total Legal Fees**

6,155

