

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,936</u>	<u>1,063</u>	<u>2,209</u>	<u>9,208</u>	8
9	SNF/PED					9
10	ICF	<u>9,403</u>		<u>129</u>	<u>9,532</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,339</u>	<u>1,063</u>	<u>2,338</u>	<u>18,740</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.26%

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

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 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 2,209

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: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	126,366	8,632		134,998		134,998	6,334	141,332		1
2	Food Purchase		129,833		129,833		129,833	(3,672)	126,161		2
3	Housekeeping	105,311	30,562		135,873		135,873	39	135,912		3
4	Laundry	6,862	10,554		17,416		17,416		17,416		4
5	Heat and Other Utilities			83,694	83,694		83,694	238	83,932		5
6	Maintenance	39,497	16,570	25,167	81,234		81,234	2,381	83,615		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	278,036	196,151	108,861	583,048		583,048	5,320	588,368		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600	22	9,622		9
10	Nursing and Medical Records	846,828	104,755	18,546	970,129		970,129	(782)	969,347		10
10a	Therapy			269,925	269,925		269,925		269,925		10a
11	Activities	43,866	313	681	44,860		44,860	(5,429)	39,431		11
12	Social Services	25,212	7		25,219		25,219		25,219		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	915,906	105,075	298,752	1,319,733		1,319,733	(6,189)	1,313,544		16
	C. General Administration										
17	Administrative			240,400	240,400		240,400	(178,600)	61,800		17
18	Directors Fees										18
19	Professional Services			14,566	14,566		14,566	80,360	94,926		19
20	Dues, Fees, Subscriptions & Promotions			7,888	7,888		7,888	167	8,055		20
21	Clerical & General Office Expenses	43,064	4,881	15,004	62,949		62,949	70,187	133,136		21
22	Employee Benefits & Payroll Taxes			180,084	180,084		180,084	16,619	196,703		22
23	Inservice Training & Education			500	500		500	29	529		23
24	Travel and Seminar							25	25		24
25	Other Admin. Staff Transportation			17,088	17,088		17,088	3,846	20,934		25
26	Insurance-Prop.Liab.Malpractice			39,280	39,280		39,280	555	39,835		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	43,064	4,881	514,810	562,755		562,755	(6,812)	555,943		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,237,006	306,107	922,423	2,465,536		2,465,536	(7,681)	2,457,855		29

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

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

Facility Name & ID Number Vandalia Rehab & Hlth Care C

#0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	
	D. Ownership											
30	Depreciation			40,964	40,964	40,964	6,145	47,109				30
31	Amortization of Pre-Op. & Org.						851	851				31
32	Interest			14,486	14,486	14,486	16,453	30,939				32
33	Real Estate Taxes			40,254	40,254	40,254	221	40,475				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			50,517	50,517	50,517	937	51,454				35
36	Other (specify):*											36
37	TOTAL Ownership			146,221	146,221	146,221	24,607	170,828				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,190		65,190	65,190		65,190				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,253	166,253	166,253		166,253				42
43	Other (specify):*		21	173,561	173,582	173,582	(173,582)					43
44	TOTAL Special Cost Centers		65,211	339,814	405,025	405,025	(173,582)	231,443				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,237,006	371,318	1,408,458	3,016,782	3,016,782	(156,656)	2,860,126				45

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

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0053058

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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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,746)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,986)	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	1,439	30		9
10	Interest and Other Investment Income	(1,286)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(270)	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	(86,639)	43		18
19	Entertainment				19
20	Contributions	(100)	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	(72,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,611)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(16,476)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,675)		\$	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	
		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)	27,019	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 27,019		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (156,656)		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Vandalia Rehab & Hlth Care C

ID# 0053058

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (6,203)	43	1
2	X-Rays-Part A	(1,554)	43	2
3	Offset Transportation Revenue	(5,429)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(105)	21	4
5	Resident Flowers	(256)	43	5
6	Disallowed Special Events	(784)	43	6
7	Offset Miscellaneous Nursing Supplies General	(800)	11	7
8	Offset Cable TV	(1,179)	43	8
9	Disallowed Chamber of Commerce Dues	(166)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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30				30
31				31
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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		(16,476)	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,759	\$ 2,759	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	66	66	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	14	14	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	186	186	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,047	1,047	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	22	22	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,379	2,379	12
13	V							13
14	Total		\$			\$ 6,474	\$ * 6,474	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 132	\$	132	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	31,056		31,056	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,412		1,412	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	16		16	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	10		10	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,512		2,512	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	443		443	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,536		2,536	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,613		1,613	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	125		125	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	638		638	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		\$			\$ 40,493	\$ *	40,493	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	72,606	72,606	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	158	158	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	1,671	1,671	28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,998	1,998	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	8,348	8,348	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 84,781	\$ *	84,781	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 Care Management, Inc.	100.00%	\$ 3,575	\$ 3,575
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	8	8
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	25	25
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	52	52
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,334	1,334
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	17	17
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	240,400	Petersen Health Care Management, Inc.	100.00%	61,800	(178,600)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	5,375	5,375
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	43	43
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,236	39,236
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	13,536	13,536
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	13	13
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15	15
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,334	1,334
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	112	112
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	172	172
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	228	228
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	96	96
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	299	299
39	Total		\$ 240,400			\$ 127,270	\$ * (113,130)

* 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 & Wellness, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health & Wellness, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health & Wellness, LLC	100.00%	0		17
18	V	5 Utilities		Petersen Health & Wellness, LLC	100.00%	0		18
19	V	6 Maintenance		Petersen Health & Wellness, LLC	100.00%	0		19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		20
21	V	9 Medical Director		Petersen Health & Wellness, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health & Wellness, LLC	100.00%	0		22
23	V	10A Therapy		Petersen Health & Wellness, LLC	100.00%	0		23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		24
25	V	17 Administrative		Petersen Health & Wellness, LLC	100.00%	0		25
26	V	19 Professional Services		Petersen Health & Wellness, LLC	100.00%	0		26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health & Wellness, LLC	100.00%	0		27
28	V	21 Clerical and General Office		Petersen Health & Wellness, LLC	100.00%	0		28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health & Wellness, LLC	100.00%	0		29
30	V	23 Inservice Training & Education		Petersen Health & Wellness, LLC	100.00%	0		30
31	V	24 Travel and Seminar		Petersen Health & Wellness, LLC	100.00%	0		31
32	V	25 Other Admin. Staff Transport.		Petersen Health & Wellness, LLC	100.00%	0		32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health & Wellness, LLC	100.00%	0		33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		34
35	V	30 Depreciation		Petersen Health & Wellness, LLC	100.00%	0		35
36	V	31 Amortization of Pre-Op. & Org.		Petersen Health & Wellness, LLC	100.00%	851	851	36
37	V	32 Interest		Petersen Health & Wellness, LLC	100.00%	7,550	7,550	37
38	V	33 Real Estate Taxes		Petersen Health & Wellness, LLC	100.00%	0		38
39	Total		\$			\$ 8,401	\$ * 8,401	39

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

Facility Name & ID Number

Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Vandalia Rehab & Hlth Care C # 0053058 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	N/A										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 Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	1,572,338	77	\$ 231,473	\$ 220,289	18,740	\$ 2,759	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	18,740	66	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	18,740	14	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	18,740	186	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	18,740	1,047	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	18,740	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	18,740	22	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	18,740	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	18,740	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	18,740	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	18,740	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	18,740	2,379	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	18,740	132	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	18,740	31,056	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	18,740	1,412	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	18,740	16	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	18,740	10	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	18,740	2,512	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	18,740	443	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	18,740	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	18,740	2,536	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	18,740	1,613	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	18,740	125	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	18,740	638	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 46,967	25

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 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

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	314,070	19	\$	\$	18,740	\$	1
2	2	Food	Resident Days	314,070	19			18,740		2
3	3	Housekeeping	Resident Days	314,070	19			18,740		3
4	4	Laundry	Resident Days	314,070	19			18,740		4
5	5	Utilities	Resident Days	314,070	19			18,740		5
6	6	Maintenance	Resident Days	314,070	19			18,740		6
7	7	Mgmt. Allocation of Benefits	Resident Days	314,070	19			18,740		7
8	10	Nursing and Medical Records	Resident Days	314,070	19			18,740		8
9	12	Social Services	Resident Days	314,070	19			18,740		9
10	17	Administrative	Resident Days	314,070	19			18,740		10
11	19	Professional Services	Resident Days	314,070	19	1,618,178		18,740	72,606	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	314,070	19	3,514		18,740	158	12
13	21	Clerical and General Office	Resident Days	314,070	19	5,004		18,740		13
14	22	Employee Benefits & Payroll	Resident Days	314,070	19	37,245		18,740	1,671	14
15	23	Inservice Training & Education	Resident Days	314,070	19			18,740		15
16	24	Travel and Seminar	Resident Days	314,070	19			18,740		16
17	25	Other Admin. Staff Transport.	Resident Days	314,070	19			18,740		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	314,070	19			18,740		18
19	27	Mgmt. Allocation of Benefits	Resident Days	314,070	19			18,740		19
20	30	Depreciation	Resident Days	314,070	19	44,535		18,740	1,998	20
21	32	Interest	Resident Days	314,070	19	186,049		18,740	8,348	21
22	33	Real Estate Taxes	Resident Days	314,070	19			18,740		22
23	34	Rent-Facility and Grounds	Resident Days	314,070	19			18,740		23
24	35	Rent-Equipment & Vehicles	Resident Days	314,070	19			18,740		24
25	TOTALS					\$ 1,894,525	\$		\$ 84,781	25

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 Management, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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	1,572,338	77	\$ 299,961	\$ 294,997	18,740	\$ 3,575	1
2	2	Food	Resident Days	1,572,338	77	675		18,740	8	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	18,740	25	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		18,740	52	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	18,740	1,334	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			18,740		6
7	9	Medical Director	Resident Days	1,572,338	77			18,740		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		18,740	17	8
9	10A	Therapy	Resident Days	1,572,338	77			18,740		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			18,740		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	18,740	61,800	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		18,740	5,375	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		18,740	43	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	18,740	39,236	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		18,740	13,536	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		18,740	13	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		18,740	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		18,740	1,334	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		18,740	112	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			18,740		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		18,740	172	21
22	32	Interest	Resident Days	1,572,338	77	19,133		18,740	228	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		18,740	96	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		18,740	299	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 127,270	25

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 & Wellness, 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	43,482	11	\$	18,740	\$	1
2	2	Food	Resident Days	43,482	11		18,740		2
3	3	Housekeeping	Resident Days	43,482	11		18,740		3
4	5	Utilities	Resident Days	43,482	11		18,740		4
5	6	Maintenance	Resident Days	43,482	11		18,740		5
6	7	Mgmt. Allocation of Benefits	Resident Days	43,482	11		18,740		6
7	9	Medical Director	Resident Days	43,482	11		18,740		7
8	10	Nursing and Medical Records	Resident Days	43,482	11		18,740		8
9	10A	Therapy	Resident Days	43,482	11		18,740		9
10	15	Mgmt. Allocation of Benefits	Resident Days	43,482	11		18,740		10
11	17	Administrative	Resident Days	43,482	11		18,740		11
12	19	Professional Services	Resident Days	43,482	11		18,740		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	43,482	11		18,740		13
14	21	Clerical and General Office	Resident Days	43,482	11		18,740		14
15	22	Employee Benefits and Payroll Tax	Resident Days	43,482	11		18,740		15
16	23	Inservice Training & Education	Resident Days	43,482	11		18,740		16
17	24	Travel and Seminar	Resident Days	43,482	11		18,740		17
18	25	Other Admin. Staff Transport.	Resident Days	43,482	11		18,740		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	43,482	11		18,740		19
20	27	Mgmt. Allocation of Benefits	Resident Days	43,482	11		18,740		20
21	30	Depreciation	Resident Days	43,482	11		18,740		21
22	31	Amortization of Pre-Op. & Org.	Resident Days	43,482	11	7,964	18,740	851	22
23	32	Interest	Resident Days	43,482	11	70,629	18,740	7,550	23
24	33	Real Estate Taxes	Resident Days	43,482	11		18,740		24
25	TOTALS					\$ 78,593	\$	\$ 8,401	25

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

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		8	9	10	11						
		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	Bank of America		X	Mortgage	Varies	01/19/07	\$ 657,483	\$ 293,450	12/31/14	Varies	\$ 14,486	1						
2												2						
3									Interest Income Offset		(1,286)	3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 657,483	\$ 293,450			\$ 13,200	9						
	B. Non-Facility Related*																	
10									Home Office Allocation-PHC		1,613	10						
11									Home Office Allocation-PHO		8,348	11						
12									Home Office Allocation-PHCM		228	12						
13									Home Office Allocation-PHW		7,550	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 17,739	14						
15	TOTALS (line 9+line14)						\$ 657,483	\$ 293,450			\$ 30,939	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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 2013 report.			\$	40,284	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.)	2013		\$	39,035	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,249)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	41,503	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.				221	
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.			\$	40,475	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>38,253</u>	8		
	2010	<u>38,321</u>	9		
	2011	<u>39,090</u>	10		
	2012	<u>39,113</u>	11		
	2013	<u>39,035</u>	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
				13	13
				14	14
				15	15
				16	16

NOTES:

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

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058 Report Period Beginning:

1/1/14 Ending:

12/31/14

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: 188,175 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 851 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
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	\$ 200,355	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Original Land Improvements	2005		13,000		15	867	867	8,236	9
10	Sidewalks	2006		7,967		15	531	531	4,514	10
11	Water Heater	2007		7,681		15	512	512	3,840	11
12	Interior Signage	2007		1,795		10	180	180	1,350	12
13	Air Conditioner	2007		5,800		15	387	387	2,902	13
14	Carpeting	2007		4,617		10	462	462	3,465	14
15	Electrical Panel Repair	2008		2,600		7	371	371	2,413	15
16	Heating Unit-Dining Room	2009		3,150		5	315	315	3,150	16
17	Sprinkler System Replacement	2010		5,850		7	836	836	3,762	17
18	Sprinkler System Replacement-Completion of 2010	2011		42,840		15	2,856	2,856	9,996	18
19	Sprinkler System Repair	2011		13,713		7	1,960	1,960	6,860	19
20	Sewer Line Repair	2011		3,365		7	480	480	1,680	20
21	Sprinkler Leak Repair	2011		4,885		7	698	698	2,443	21
22	Water Leak Repair	2012		2,531	#	7	362	362	905	22
23	Sewer Line Repair	2012		3,219		7	460	460	1,150	23
24	Smoke Detector Installation	2012		2,907		10	290	290	725	24
25	Bathroom Fixtures	2013		4,399		7	628	628	942	25
26	Water Pipe Repair	2013		7,571		7	1,082	1,082	1,623	26
27	Entrance to Building	2014		3,734		7	133	133	133	27
28	Panic Bar	2014		2,776		7	99	99	99	28
29	Carpet and Ceramic Tile in Halls, Walls, Dining Room	2014		16,850		15	187	187	187	29
30	Electrical Power Feeds	2014		3,875		15	21	21	21	30
31	Deck, Ramp and Rail Replacement	2014		11,799		15				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 and Improvement Costs-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					1,398		(1,398)	63
64					21,155		(21,155)	64
65					11,218		(11,218)	65
66								66
67			8,748		210		210	67
68			817		45		45	68
69								69
70		\$ 713,739	\$ 33,771		\$ 35,062	\$ 1,291	\$ 260,751	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 55,135	\$ 5,054	\$ 5,457	\$ 403	5-10 yrs.	\$ 41,734	71
72	Current Year Purchases	41,352	2,139	2,139		10 yrs.	2,139	72
73	Fully Depreciated Assets	112,263					112,263	73
74	Home Office Allocation			4,451	4,451			74
75	TOTALS	\$ 208,750	\$ 7,193	\$ 12,047	\$ 4,854		\$ 156,136	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 951,739	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,109	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,145	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 416,887	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.

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning: 1/1/14

Ending: 12/31/14

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 44,516 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

* 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 Rehab & Hlth Care C
0053058**

Period Beginning 1/1/2014
Period End 12/31/2014

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 36,854
Dishwasher	598
Laundry Equipment	59
Copier	6,068
Home Office Allocation	937
	<u>44,516</u>

Facility Name & ID Number Vandalia Rehab & Hlth Care C # 0053058 Report Period Beginning: 1/1/14 Ending: 12/31/14
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>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,703	\$ 100,551	\$	6,703	\$ 100,551	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,348	35,213		2,348	35,213	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		8,944	134,161		8,944	134,161	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				65,190		65,190	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	17,995	\$ 269,925	\$ 65,190	17,995	\$ 335,115	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 Rehab & Hlth Care C

0053058

Report Period Beginning: 1/1/14

Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	\$ (81,506)	\$ (81,506)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>69,014</u>)	734,605	734,605	3
4	Supply Inventory (priced at <u>Cost</u>)	10,381	10,381	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,808	41,808	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(64,613)	(64,613)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 640,675	\$ 640,675	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,217	29,250	13
14	Buildings, at Historical Cost	527,250	535,998	14
15	Leasehold Improvements, at Historical Cost	155,957	177,741	15
16	Equipment, at Historical Cost	215,950	208,750	16
17	Accumulated Depreciation (book methods)	(432,103)	(416,887)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 517,271	\$ 534,852	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,157,946	\$ 1,175,527	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,054,310	\$ 1,054,310	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,414	63,414	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,755	34,755	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,503	41,503	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	30,030	30,030	36
37	<u>Accrued Management Fees</u>	210,726	210,726	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,434,738	\$ 1,434,738	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	293,450	293,450	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	10,084	10,084	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 303,534	\$ 303,534	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,738,272	\$ 1,738,272	46
47	TOTAL EQUITY(page 18, line 24)	\$ (580,326)	\$ (562,745)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,157,946	\$ 1,175,527	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 886,549	1
2	Restatements (describe):		2
3	Rounding	1	3
4	Prior Period Adjustment	(991)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 885,559	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	206,737	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)	\$ 206,737	17
B. Transfers (Itemize):			
18	Transfer of Net Assets due to Corporate Restructuring	(1,672,622)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,672,622)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (580,326)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,794,021	1
2	Discounts and Allowances for all Levels	(257,036)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,536,985	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	516,769	6
7	Oxygen	954	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 517,723	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	3,746	14
15	Telephone, Television and Radio	1,179	15
16	Rental of Facility Space		16
17	Sale of Drugs	133,801	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,048	20
21	Other Medical Services	13,417	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,191	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,286	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,286	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	905	28
28a	Transportation Revenue	5,429	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,334	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,223,519	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	583,048	31
32	Health Care	1,319,733	32
33	General Administration	562,755	33
B. Capital Expense			
34	Ownership	146,221	34
C. Ancillary Expense			
35	Special Cost Centers	238,772	35
36	Provider Participation Fee	166,253	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,016,782	40
41	Income before Income Taxes (line 30 minus line 40)**	206,737	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 206,737	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,915,398	44
45	Private Pay - Net Inpatient Revenue	126,423	45
46	Medicare - Net Inpatient Revenue	477,574	46
47	Other-(specify) <u>Insurance Net Revenue</u>	20,426	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(2,836)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,536,985	49

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

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

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

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

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	2,169	2,185	60,812	\$ 27.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,347	4,562	99,397	21.79	3
4	Licensed Practical Nurses	12,881	13,708	240,271	17.53	4
5	CNAs & Orderlies	38,853	40,211	378,167	9.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,039	20,582	10.10	9
10	Activity Assistants	11	11	91	8.27	10
11	Social Service Workers	1,937	1,995	25,212	12.64	11
12	Dietician					12
13	Food Service Supervisor	2,003	2,033	26,300	12.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,038	11,482	100,066	8.71	15
16	Dishwashers					16
17	Maintenance Workers	2,041	2,136	39,497	18.49	17
18	Housekeepers	10,984	11,635	105,311	9.05	18
19	Laundry	705	790	6,862	8.68	19
20	Administrator	2,080	2,080	61,800	29.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,080	2,080	43,064	20.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	5,016	5,310	91,374	17.21	33
34	TOTAL (lines 1 - 33)	98,111	102,258	\$ 1,298,806 *	\$ 12.70	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	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,949	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	5 226	L10, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	5 \$ 13,775		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Vandalia Rehab & Hlth Care C
0053058

Period Beginning 1/1/2014
Period End 12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,054	3,165	68,181	21.54
Transportation	1,962	2,144	23,193	10.82
TOTAL	<u>5,016</u>	<u>5,310</u>	<u>91,374</u>	

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	
Michelle Blain	Administrator	0	\$ 61,800	Workers' Compensation Insurance	\$ 61,279	IDPH License Fee	\$ 5,970	
				Unemployment Compensation Insurance	36,389	Advertising: Employee Recruitment		
				FICA Taxes	93,378	Health Care Worker Background Check		
				Employee Health Insurance	(13,216)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	443	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	280	
				Employee Relations	1,381	Miscellaneous Dues & Subscriptions	1,195	
				Employee Retirement	873	Home Office Allocation	333	
				Home Office Allocation	16,619			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,800	TOTAL (agree to Schedule V, line 22, col.8)		\$ 8,055		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(166)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 240,400				Non-allowable advertising	
							()	
							Yellow page advertising	
							()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 240,400				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 3,087				Out-of-State Travel	\$
New Wave Communications	Computer Services		1,763					
Honkamp Krueger & Co.	Accounting Fees		1,043					
Sorling Northrup	Legal Fees		7,688	N/A			In-State Travel	
Illinois Real Estate Svcs	Legal Fees		172					
Illinois Secretary of State	Filing Fees		130					
Clinton County Title Co.	Filing Fees		233					
Effingham County Clerk	Filing Fees		104				Seminar Expense	
Secretary of State	Filing Fees		250					
Clinton County Recorder	Filing Fees		41				Home Office Allocation	25
Bond County Recorder	Filing Fees		55					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 14,566	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 25	

* Attach copy of IMRF notifications

**See instructions.

**Vandalia Rehab & Hlth Care C
0053058**

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		14,566
Home Office Allocation		
Lexis Nexis	Legal	7
GoffWilson	Legal	437
Illinois Secretary of State	Legal	40
Bank of America	Legal	132
Healthcare Resources International	Legal	79
Miscellaneous	Legal	17
Addy, Bush	Legal	11
Hall, Rustom, and Fritz	Legal	13
Black, Hedin, Ballard	Legal	23
SmithAmundsen	Legal	23
CliftonLarson Allen	Accountants	929
Ginoli & Co.	Accountants	2,013
Miscellaneous	Computer Services	14
Odessian LLC	Computer Services	5
Optimizer	Computer Services	37
Allpayer Exchange	Computer Services	12
CCH	Computer Services	20
Prism Software	Computer Services	60
Macquarie Technology Services	Computer Services	52
Advanced Answers on Demand	Computer Services	2,752
Stratus Networks	Computer Services	363
Kemper Technology	Computer Services	1,074
AT&T	Computer Services	5
Ability Network	Computer Services	416
Barracuda	Computer Services	95

CIAN	Computer Services	113
Comcast	Computer Services	29
Emdeon	Computer Services	73
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	5
Better Banks	Other Prof Fees	3
David Budde	Other Prof Fees	32
All Scripts	Other Prof Fees	22
Miscellaneous	Other Prof Fees	3
Registered Agent Solutions	Other Prof Fees	14
MGBD	Other Prof Fees	71,431
Total (agree to Schedule V, line 19, column 8)		<u>94,925</u>

**Vandalia Rehab & Hlth Care C
0053058**

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Home Office Allocation

Lexis Nexis	Legal	7
GoffWilson	Legal	437
Illinois Secretary of State	Legal	40
Bank of America	Legal	132
Healthcare Resources International	Legal	79
Miscellaneous	Legal	17
Addy, Bush	Legal	11
Hall, Rustom, and Fritz	Legal	13
Black, Hedin, Ballard	Legal	23
SmithAmundsen	Legal	23

Direct Facility Invoices

Sorling Northrup-White Case	2/10/2014	1,662
Sorling Northrup-White Case	3/10/2014	46
Sorling Northrup-White Case	3/11/2014	46
Sorling Northrup-White Case	7/8/2014	92
Sorling Northrup-White Case	8/11/2014	161
Sorling Northrup-White Case	9/9/2014	1,081
Sorling Northrup-White Case	10/8/2014	1,012
Sorling Northrup-White Case	11/10/2014	299
Sorling Northrup-White Case	12/3/2014	3,289
Effingham County Clerk-Filing Fees	2/27/2014	104
Clinton County Tile-Property Filing Fees	7/30/2014	233
Illinois Secretary of State-Property Title Fees	8/8/2014	172
Bond County Recorder-Filing Fees	8/13/2014	55
Clinton County Tile-Property Filing Fees	8/13/2014	41
Illinois Secretary of State-Filing Fees	10/7/2014	100
Illinois Secretary of State-Filing Fees	10/7/2014	30
Illinois Secretary of State-Filing Fees	11/18/2014	250

Total Legal Fees (agree to Schedule V, line 19, column 8)

9,455

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

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

Facility Name & ID Number Vandalia Rehab & Hlth Care C# 0053058

Report Period Beginning:

1/1/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$711.83
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,886 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,253
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? Yes Indicate the amount. \$ 3,746
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 5,429
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adquate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.