

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: <u>0053058</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Vandalia Rehab & Hlth Care C</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1500 W St Louis Ave</u> <u>Vandalia</u> <u>62471</u>																									
Number City Zip Code																									
County: <u>Fayette</u>																									
Telephone Number: <u>(618) 283-4262</u> Fax # <u>(618) 283-4313</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>10/01/2005</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,297</u>	<u>1,045</u>	<u>1,622</u>	<u>16,964</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,297</u>	<u>1,045</u>	<u>1,622</u>	<u>16,964</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.07%

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 1,346

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Vandalia Rehab & Hlth Care C # 0053058 Report Period Beginning: 1/1/2016 Ending: 12/31/2016
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	131,130	11,491		142,621		142,621	3,485	146,106			1
2	Food Purchase		112,325		112,325		112,325	(2,752)	109,573			2
3	Housekeeping	112,839	28,723		141,562		141,562	61	141,623			3
4	Laundry	1,557	18,390		19,947		19,947		19,947			4
5	Heat and Other Utilities			90,262	90,262		90,262	203	90,465			5
6	Maintenance	43,490	12,326	35,276	91,092		91,092	1,902	92,994			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	289,016	183,255	125,538	597,809		597,809	2,899	600,708			8
	B. Health Care and Programs											
9	Medical Director			14,500	14,500		14,500		14,500			9
10	Nursing and Medical Records	882,758	102,176	4,875	989,809		989,809	(1,267)	988,542			10
10a	Therapy			189,222	189,222		189,222		189,222			10a
11	Activities	43,858	288	457	44,603		44,603	(8,392)	36,211			11
12	Social Services	27,025			27,025		27,025		27,025			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Office Ben. Allocation</u>											15
16	TOTAL Health Care and Programs	953,641	102,464	209,054	1,265,159		1,265,159	(9,659)	1,255,500			16
	C. General Administration											
17	Administrative			217,000	217,000		217,000	(152,700)	64,300			17
18	Directors Fees											18
19	Professional Services			6,048	6,048		6,048	22,552	28,600			19
20	Dues, Fees, Subscriptions & Promotions			8,115	8,115		8,115	(383)	7,732			20
21	Clerical & General Office Expenses	45,354	2,706	16,681	64,741		64,741	40,594	105,335			21
22	Employee Benefits & Payroll Taxes			177,181	177,181		177,181	22,714	199,895			22
23	Inservice Training & Education							78	78			23
24	Travel and Seminar							38	38			24
25	Other Admin. Staff Transportation			8,572	8,572		8,572	3,196	11,768			25
26	Insurance-Prop.Liab.Malpractice			35,122	35,122		35,122	450	35,572			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	45,354	2,706	468,719	516,779		516,779	(63,461)	453,318			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,288,011	288,425	803,311	2,379,747		2,379,747	(70,221)	2,309,526			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			48,071	48,071		48,071	8,761	56,832			30
31	Amortization of Pre-Op. & Org.							23,957	23,957			31
32	Interest			94,764	94,764		94,764	36,095	130,859			32
33	Real Estate Taxes			42,524	42,524		42,524	207	42,731			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			59,633	59,633		59,633	731	60,364			35
36	Other (specify):*											36
37	TOTAL Ownership			244,992	244,992		244,992	69,751	314,743			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,850		79,850		79,850		79,850			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			157,085	157,085		157,085		157,085			42
43	Other (specify):*		466	41,069	41,535		41,535	(41,535)				43
44	TOTAL Special Cost Centers		80,316	198,154	278,470		278,470	(41,535)	236,935			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,288,011	368,741	1,246,457	2,903,209		2,903,209	(42,005)	2,861,204			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,815)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,961)	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	(228)	30		9
10	Interest and Other Investment Income	(67)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(197)	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	(7,311)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,000)	43		24
25	Fund Raising, Advertising and Promotional	(2,553)	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	(25,058)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,190)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,185	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,185		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (42,005)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,589)	43	1
2	X-Rays-Part A	(5,630)	43	2
3	Offset Transportation Revenue	(8,392)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(29)	21	4
5	Resident Flowers	(101)	43	5
6	Disallowed Special Events	(966)	43	6
7	Offset Miscellaneous Nursing Supplies General	(1,370)	11	7
8	Offset Cable TV	(1,227)	43	8
9	Disallowed Chamber of Commerce Dues	(754)	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
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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	(25,058)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2016

Ending:

12/31/2016**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,485	0	0	0	0	0	0	0	0	0	3,485	1
2	Food Purchase	(2,815)	63	0	0	0	0	0	0	0	0	0	(2,752)	2
3	Housekeeping	0	61	0	0	0	0	0	0	0	0	0	61	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	203	0	0	0	0	0	0	0	0	0	203	5
6	Maintenance	0	1,902	0	0	0	0	0	0	0	0	0	1,902	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,815)	5,714	0	0	0	0	0	0	0	0	0	2,899	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	103	0	0	0	0	0	0	0	0	0	103	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(9,762)	0	0	0	0	0	0	0	0	0	0	(9,762)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9,762)	103	0	0	0	0	0	0	0	0	0	(9,659)	16
	C. General Administration													
17	Administrative	0	(152,700)	0	0	0	0	0	0	0	0	0	(152,700)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,874	0	13,678	0	0	0	0	0	0	0	22,552	19
20	Fees, Subscriptions & Promotions	(754)	0	371	0	0	0	0	0	0	0	0	(383)	20
21	Clerical & General Office Expenses	(29)	0	40,623	0	0	0	0	0	0	0	0	40,594	21
22	Employee Benefits & Payroll Taxes	0	0	22,714	0	0	0	0	0	0	0	0	22,714	22
23	Inservice Training & Education	0	0	78	0	0	0	0	0	0	0	0	78	23
24	Travel and Seminar	0	0	38	0	0	0	0	0	0	0	0	38	24
25	Other Admin. Staff Transportation	0	0	3,196	0	0	0	0	0	0	0	0	3,196	25
26	Insurance-Prop.Liab.Malpractice	0	0	450	0	0	0	0	0	0	0	0	450	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(783)	(143,826)	67,470	13,678	0	0	0	0	0	0	0	(63,461)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,360)	(138,009)	67,470	13,678	0	0	0	0	0	0	0	(70,221)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Vandalia Rehab & Hlth Care C # 0053058 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(228)	0	8,989	0	0	0	0	0	0	0	0	8,761	30
31	Amortization of Pre-Op. & Org.	0	0	0	23,957	0	0	0	0	0	0	0	23,957	31
32	Interest	(67)	0	264	35,898	0	0	0	0	0	0	0	36,095	32
33	Real Estate Taxes	0	0	207	0	0	0	0	0	0	0	0	207	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	731	0	0	0	0	0	0	0	0	731	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(295)	0	10,191	59,855	0	0	0	0	0	0	0	69,751	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(41,535)	0	0	0	0	0	0	0	0	0	0	(41,535)	43
44	TOTAL Special Cost Centers	(41,535)	0	0	0	0	0	0	0	0	0	0	(41,535)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,190)	(138,009)	77,661	73,533	0	0	0	0	0	0	0	(42,005)	45

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.

[illegible]

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 Management, Inc.	100.00%	\$ 3,485	\$ 3,485	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	63	63	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	61	61	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	203	203	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,902	1,902	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	103	103	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	217,000	Petersen Health Care Management, Inc.	100.00%	64,300	(152,700)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	8,874	8,874	12
13	V								13
14	Total			\$ 217,000			\$ 78,991	\$ * (138,009)	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 & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 371	\$	371
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	40,623		40,623
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	22,714		22,714
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	78		78
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	38		38
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,196		3,196
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	450		450
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	8,989		8,989
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	264		264
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	207		207
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	731		731
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$ 77,661	\$ *	77,661

* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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	4 Laundry		Petersen Health Wellness, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Wellness, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Wellness, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		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	15 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Wellness, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Wellness, LLC	100.00%	13,678	13,678	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Wellness, LLC	100.00%	0		33
34	V	31 Amortization		Petersen Health Wellness, LLC	100.00%	23,957	23,957	34
35	V	32 Interest		Petersen Health Wellness, LLC	100.00%	35,898	35,898	35
36	V	33 Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0		38
39	Total		\$			\$ 73,533	\$ * 73,533	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:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Vandalia Rehab & Hlth Care C # 0053058 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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 Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	16,964	\$ 3,485	1
2	2	Food	Resident Days	75	5,673	0	16,964	63	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	16,964	61	3
4	5	Utilities	Resident Days	75	18,209	0	16,964	203	4
5	6	Maintenance	Resident Days	75	170,632	137,057	16,964	1,902	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,964	0	6
7	9	Medical Director	Resident Days	75	0	0	16,964	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	16,964	103	8
9	10A	Therapy	Resident Days	75	0	0	16,964	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,964	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	16,964	64,300	11
12	19	Professional Services	Resident Days	75	795,918	0	16,964	8,874	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	16,964	371	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	16,964	40,623	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	16,964	22,714	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	16,964	78	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	16,964	38	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	16,964	3,196	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	16,964	450	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,964	0	20
21	30	Depreciation	Resident Days	75	806,271	0	16,964	8,989	21
22	32	Interest	Resident Days	75	23,686	0	16,964	264	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	16,964	207	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	16,964	731	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 156,652	25

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

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	94,948	7	\$	\$	16,964	\$	1
2	2	Food	Resident Days	94,948	7			16,964		2
3	3	Housekeeping	Resident Days	94,948	7			16,964		3
4	4	Laundry	Resident Days	94,948	7			16,964		4
5	5	Utilities	Resident Days	94,948	7			16,964		5
6	6	Maintenance	Resident Days	94,948	7			16,964		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,948	7			16,964		7
8	10	Nursing and Medical Records	Resident Days	94,948	7			16,964		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,948	7			16,964		9
10	17	Administrative	Resident Days	94,948	7			16,964		10
11	19	Professional Services	Resident Days	94,948	7	76,557		16,964	13,678	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,948	7			16,964		12
13	21	Clerical and General Office	Resident Days	94,948	7			16,964		13
14	22	Employee Benefits & Payroll	Resident Days	94,948	7			16,964		14
15	23	Inservice Training & Education	Resident Days	94,948	7			16,964		15
16	24	Travel and Seminar	Resident Days	94,948	7			16,964		16
17	25	Other Admin. Staff Transport.	Resident Days	94,948	7			16,964		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,948	7			16,964		18
19	30	Depreciation	Resident Days	94,948	7			16,964		19
20	31	Amortization	Resident Days	94,948	7	134,086		16,964	23,957	20
21	32	Interest	Resident Days	94,948	7	200,924		16,964	35,898	21
22	33	Real Estate Taxes	Resident Days	94,948	7			16,964		22
23	34	Rent-Facility and Grounds	Resident Days	94,948	7			16,964		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,948	7			16,964		24
25	TOTALS					\$ 411,567	\$		\$ 73,533	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Gemino		X	Mortgage	Varies	5/10/16	\$ 1,846,848	\$ 1,767,647	5/9/26	Varies	\$ 94,764	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,846,848	\$ 1,767,647			\$ 94,764	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(67)	10	
11								Home Office Allocation-PHCM			264	11	
12								Home Office Allocation-PHW			35,898	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 36,095	14	
15	TOTALS (line 9+line14)						\$ 1,846,848	\$ 1,767,647			\$ 130,859	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 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.)

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

B. Real Estate Taxes

[illegible]

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Vandalia Rehab & Hlth Care C COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0053058

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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:

23,957

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	159,430	2005	\$ 29,250	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	\$ 242,535
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2005	13,000		15	867	867	9,103
10	Water Heater			2007	7,681		15	512	512	4,864
11	Air Conditioner			2007	5,800		15	387	387	3,676
12	Carpeting			2007	4,617		10	462	462	4,389
13	Electrical Panel Repair			2008	2,600		7			2,600
14	Heating Unit-Dining Room			2009	3,150		5			3,150
15	Sprinkler System Replacement			2010	5,850		7	836	836	5,434
16	Sprinkler System Replacement-Completion of 2010			2011	42,840		15	2,856	2,856	15,708
17	Sprinkler System Repair			2011	13,713		7	1,960	1,960	10,780
18	Sewer Line Repair			2011	3,365		7	480	480	2,640
19	Sprinkler Leak Repair			2011	4,885		7	698	698	3,839
20	Water Leak Repair			2011	2,531		7	362	362	1,629
21	Sewer Line Repair			2011	3,219		7	460	460	2,070
22	Smoke Detector Installation			2012	2,907		10	290	290	1,305
23	Bathroom Fixtures			2013	4,399		7	628	628	2,198
24	Water Pipe Repair			2013	7,571		7	1,082	1,082	3,787
25	Entrance to Building			2014	3,734		7	534	534	1,335
26	Panic Bar			2014	2,776		7	397	397	993
27	Carpet and Ceramic Tile in Halls, Walls, Dining Room			2014	16,850		15	562	562	1,405
28	Electrical Power Feeds			2014	3,875		15	258	258	645
29	Deck, Ramp and Rail Replacement			2014	11,799		15	787	787	1,967
30	Roof Repairs			2014	26,018		15	868	868	1,736
31	Sprinkler Line Repair			2016	2,964		7	212	212	212
32	Sewer Line Repair			2016	6,450		7	461	461	461
33										
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

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		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	Land Improvements Booked			1,398			(1,398)		63
64	Building Booked			21,155			(21,155)		64
65	Building Improvement Booked			14,737			(14,737)		65
66									66
67	2016-Home Office Allocation-Building Improvements		7,490			180	180		67
68	2016-Home Office Allocation-Land Improvements		689			45	45		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 738,023	\$ 37,290		\$ 37,274	\$ (16)	\$ 328,461	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	\$107,932	\$10,393	\$10,794	\$401	5-10 yrs.	\$50,662	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	126,171					126,171	73
74	Home Office Allocation			8,764	8,764			74
75	TOTALS	\$234,103	\$10,393	\$19,558	\$9,165		\$176,833	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	1,001,376
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	47,683
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	56,832
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	9,149
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	505,294

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
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: 1/1/2016

Ending: 12/31/2016

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: \$ **53,426** Description: **See Attached Schedule 14A**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	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. 2017 \$

13. /2018 \$

14. /2019 \$

*** 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 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	47,295
Dishwasher		705
Copier		4,695
Home Office Allocation		731
		<u>53,426</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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	\$	5,397	\$ 80,952	\$	5,397	\$ 80,952	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		652	9,776		652	9,776	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,566	98,494		6,566	98,494	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				79,850		79,850	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			\$	12,615	\$ 189,222	\$ 79,850	12,615	\$ 269,072	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.

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	\$ 840,880	\$ 840,880	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,072)	873,227	873,227	3
4	Supply Inventory (priced at Cost)	10,381	10,381	4
5	Short-Term Investments			5
6	Prepaid Insurance	33,307	33,307	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	189	189	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,757,984	\$ 1,757,984	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	534,740	14
15	Leasehold Improvements, at Historical Cost	191,389	203,283	15
16	Equipment, at Historical Cost	234,103	234,103	16
17	Accumulated Depreciation (book methods)	(529,281)	(505,294)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	109,091	109,091	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 582,769	\$ 605,173	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,340,753	\$ 2,363,157	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 588,289	\$ 588,289	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,354	68,354	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,697	28,697	31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,504	83,504	32
33	Accrued Interest Payable	7,211	7,211	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	95,432	95,432	36
37	<u>Accrued Management Fees</u>	430,112	430,112	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,301,599	\$ 1,301,599	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,767,647	1,767,647	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	10,207	10,207	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,777,854	\$ 1,777,854	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,079,453	\$ 3,079,453	46
47	TOTAL EQUITY(page 18, line 24)	\$ (738,700)	\$ (716,296)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,340,753	\$ 2,363,157	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (635,903)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(12,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (647,903)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(90,797)	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)	\$ (90,797)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (738,700)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Vandalia Rehab & Hlth Care C

0053058

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 2,586,749	1
2	Discounts and Allowances for all Levels	(310,599)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,276,150	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	346,965	6
7	Oxygen	375	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 347,340	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	2,815	14
15	Telephone, Television and Radio	1,227	15
16	Rental of Facility Space		16
17	Sale of Drugs	132,159	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,770	20
21	Other Medical Services	29,093	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 179,064	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 67	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	8,392	28
28a	<u>Miscellaneous Revenue</u>	1,399	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,791	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,812,412	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	597,809	31
32	Health Care	1,265,159	32
33	General Administration	516,779	33
	B. Capital Expense		
34	Ownership	244,992	34
	C. Ancillary Expense		
35	Special Cost Centers	121,385	35
36	Provider Participation Fee	157,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,903,209	40
41	Income before Income Taxes (line 30 minus line 40)**	(90,797)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (90,797)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,904,166	44
45	Private Pay - Net Inpatient Revenue	142,783	45
46	Medicare - Net Inpatient Revenue	182,737	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	46,464	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,276,150	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.

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	2,080	2,080	\$ 62,902	\$ 30.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,020	4,151	89,440	21.55	3
4	Licensed Practical Nurses	14,568	15,065	283,149	18.80	4
5	CNAs & Orderlies	36,920	37,880	401,600	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,977	2,027	21,641	10.68	9
10	Activity Assistants	18	18	187	10.39	10
11	Social Service Workers	1,924	2,040	27,025	13.25	11
12	Dietician					12
13	Food Service Supervisor	2,426	2,490	32,521	13.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,802	10,866	98,609	9.08	15
16	Dishwashers					16
17	Maintenance Workers	2,073	2,182	43,490	19.93	17
18	Housekeepers	11,939	12,266	112,839	9.20	18
19	Laundry	174	174	1,557	8.95	19
20	Administrator	2,080	2,080	64,300	30.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	45,354	21.80	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: CPC	2,080	2,080	45,667	21.96	32
33	Other(specify) Transportation	1,511	1,567	22,030	14.06	33
34	TOTAL (lines 1 - 33)	96,672	99,046	\$ 1,352,311 *	\$ 13.65	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		\$	L1, C3	35
36	Medical Director	Monthly	14,500	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,697	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	347	L10A, 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)	6	\$ 18,544		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Michelle Vaughan	Administrator	0	\$ 64,300
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,300
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 217,000
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 217,000
(Attach a copy of any management service agreement)			
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 3,223
New Wave Communications	Computer Services		1,920
Honkamp Krueger & Co.	Accounting Fees		768
Sorling Northrup	Legal Fees		137
TOTAL (agree to Schedule V, line 19, column 3)			
(For legal fee disclosure, see page 39 of instructions)			\$ 6,048
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 39,255
Unemployment Compensation Insurance			31,858
FICA Taxes			96,747
Employee Health Insurance			7,434
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			1,277
Employee Retirement			610
Home Office Allocation			22,714
TOTAL (agree to Schedule V, line 22, col.8)			\$ 199,895
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 3,980
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)	57		737
Patient Background Checks	22		287
Miscellaneous Licenses & Permits			457
Miscellaneous Dues & Subscriptions			2,654
Home Office Allocation			371
Less: Public Relations Expense			(754)
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,732
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			38
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 38

*** Attach copy of IMRF notifications**

****See instructions.**

Vandalia Rehab & Hlth Care C
0053058
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,048
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	40
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	69
Healthcare Resources International	Legal	342
Hunziker Law	Legal	82
Lexis Nexis	Legal	7
Gemino	Legal	6,162
Illinois Secretary of State	Legal	45
Peoria County Recorder	Legal	18
CliftonLarson Allen	Accountants	356
Ginoli & Co.	Accountants	3,613
Miscellaneous	Computer Services	45
Change Healthcare	Computer Services	7
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	3,124
Stratus Networks	Computer Services	318
Kemper Technology	Computer Services	209
AT&T	Computer Services	5
Ability Network	Computer Services	1,332
CIAN	Computer Services	159
Comcast	Computer Services	26
CCH	Computer Services	10
Charter Communications	Computer Services	31
Allscripts	Computer Services	464
ATS	Computer Services	210
Allpayer Exchange	Computer Services	11
Optimizer	Other Prof Fees	32
Ankura	Other Prof Fees	242
David Budde	Other Prof Fees	28
Bruner, Cooper, Zuck	Other Prof Fees	71
Marotta, Gund, Budd, Dzerda	Other Prof Fees	5,439
Professional Software and Services	Other Prof Fees	17
Hughes Valuation Services	Other Prof Fees	22
Alan Litwiller	Other Prof Fees	2

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

28,600

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?
If YES, give association name and amount.

Yes
IHCA \$1500
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 12,600 Line 10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9)

Are you presently operating under a sublease agreement?

YES X NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 157,085
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 2,815
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 8,392

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees

No

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Det	-42,005	equal to	-42,005	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	130,859	equal to	130,859	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	42,731	equal to	42,731	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	23,957	equal to	23,957	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	56,832	equal to	56,832	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	60,364	equal to	60,364	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	189,222	equal to	189,222	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	79,850	equal to	79,850	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	597,809	equal to	597,809	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,265,159	equal to	1,265,159	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	516,779	equal to	516,779	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	244,992	equal to	244,992	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	121,385	equal to	121,385	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pr	157,085	equal to	157,085	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	882,758	equal to	882,758	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	43,858	equal to	43,858	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	27,025	equal to	27,025	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	131,130	equal to	131,130	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	43,490	equal to	43,490	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	112,839	equal to	112,839	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	1,557	equal to	1,557	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	64,300	equal to	64,300	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	45,354	equal to	45,354	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,352,311	equal to	1,288,011	64,300	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,500	< or = to	14,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	4,044	< or = to	4,875	-831	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	457	-457	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	64,300	equal to	64,300	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	217,000	equal to	217,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	6,048	equal to	6,048	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	199,895	equal to	199,895	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	7,732	equal to	7,732	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	38	equal to	38	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	157,085	equal to	157,085	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	1,346	equal to	1,622	-276	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	13,185	equal to	13,185	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	1,767,647	equal to	1,767,647	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax	83,504	equal to	83,504	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	29,250	equal to	29,250	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	738,023	equal to	738,023	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and	234,103	equal to	234,103	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	505,294	equal to	505,294	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-738,700	equal to	-738,700	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	-90,797	equal to	-90,797	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,340,753	equal to	2,340,753	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	131,130	11,491	0	142,621	0	142,621	3,485	146,106
2. Food Purchase	0	112,325	0	112,325	0	112,325	-2,752	109,573
3. Housekeeping	112,839	28,723	0	141,562	0	141,562	61	141,623
4. Laundry	1,557	18,390	0	19,947	0	19,947	0	19,947
5. Heat and Other Utilities	0	0	90,262	90,262	0	90,262	203	90,465
6. Maintenance	43,490	12,326	35,276	91,092	0	91,092	1,902	92,994
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	289,016	183,255	125,538	597,809	0	597,809	2,899	600,708
9. Medical Director	0	0	14,500	14,500	0	14,500	0	14,500
10. Nursing & Medical Records	882,758	102,176	4,875	989,809	0	989,809	-1,267	988,542
10a. Therapy	0	0	189,222	189,222	0	189,222	0	189,222
11. Activities	43,858	288	457	44,603	0	44,603	-8,392	36,211
12. Social Services	27,025	0	0	27,025	0	27,025	0	27,025
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	953,641	102,464	209,054	1,265,159	0	1,265,159	-9,659	#####
17. Administrative	0	0	217,000	217,000	0	217,000	-152,700	64,300
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	6,048	6,048	0	6,048	22,552	28,600
20. Fees, Subscriptions & Promotion	0	0	8,115	8,115	0	8,115	-383	7,732
21. Clerical & General Office	45,354	2,706	16,681	64,741	0	64,741	40,594	105,335
22. Employee Benefits & Payroll	0	0	177,181	177,181	0	177,181	22,714	199,895
23. Inservice Training & Education	0	0	0	0	0	0	78	78
24. Travel and Seminar	0	0	0	0	0	0	38	38
25. Other Admin. Staff Trans	0	0	8,572	8,572	0	8,572	3,196	11,768
26. Insurance-Prop.Liab.Malpractice	0	0	35,122	35,122	0	35,122	450	35,572
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	45,354	2,706	468,719	516,779	0	516,779	-63,461	453,318
29. Total General Administrative	1,288,011	288,425	803,311	2,379,747	0	2,379,747	-70,221	#####
30. Depreciation	0	0	48,071	48,071	0	48,071	8,761	56,832
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	23,957	23,957
32. Interest	0	0	94,764	94,764	0	94,764	36,095	130,859
33. Real Estate	0	0	42,524	42,524	0	42,524	207	42,731
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	59,633	59,633	0	59,633	731	60,364
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	244,992	244,992	0	244,992	69,751	314,743
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	79,850	0	79,850	0	79,850	0	79,850
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	157,085	157,085	0	157,085	0	157,085
43. Other (specify):*	0	466	41,069	41,535	0	41,535	-41,535	0
44. Total Special Cost Ce	0	80,316	198,154	278,470	0	278,470	-41,535	236,935
45. Grand Total	1,288,011	368,741	1,246,457	2,903,209	0	2,903,209	-42,005	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	840,880	840,880
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	873,227	873,227
4. Supply Inventory	10,381	10,381
5. Short-Term Investments	0	0
6. Prepaid Insurance	33,307	33,307
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	189	189
10. Total current assets	1,757,984	1,757,984
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	50,217	29,250
14. Buildings, at Historical Cost	527,250	534,740
15. Leasehold Improvements, Historical Cost	191,389	203,283
16. Equipment, at Historical Cost	234,103	234,103
17. Accumulated Depreciation (book methods)	-529,281	-505,294
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	109,091	109,091
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	582,769	605,173
25. Total Assets	2,340,753	2,363,157
CURRENT LIABILITIES		
26. Accounts Payable	588,289	588,289
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	68,354	68,354
31. Accrued Taxes Payable	28,697	28,697
32. Accrued Real Estate Taxes	83,504	83,504
33. Accrued Interest Payable	7,211	7,211
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	95,432	95,432
37. Other Current Liabilities (specify):	430,112	430,112
38. Total Current Liabilities	1,301,599	1,301,599
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,767,647	1,767,647
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	10,207	10,207
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,777,854	1,777,854
46.Total Liabilities	3,079,453	3,079,453
47.Total Equity	-738,700	-716,296
48.Total Liabilities and Equity	2,340,753	2,363,157

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,586,749
2. Discounts and Allowances for all Levels	-310,599
Subtotal - Inpatient Care	2,276,150
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	346,965
7. Oxygen	375
Subtotal - Ancillary Revenue	347,340
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,815
15. Telephone, Television, and Radio	1,227
16. Rental of Facility Space	0
17. Sale of Drugs	132,159
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	13,770
21. Other Medical Services	29,093
22. Laundry	0
Subtotal - Other Operating Revenue	179,064
24. Contributions	0
25. Interest and Other Investments Income	67
Subtotal - Non-Operating Revenue	67
27. Other Revenue (specify):	8,392
28. Other Revenue (specify):	1,399
Subtotal - Other Revenue	9,791
30. Total Revenue	2,812,412
31. General Services	586,007
32. Health Care	1,216,220
33. General Administration	518,341
34. Ownership	186,791
35. Special Cost Centers	178,054
35. Provider Participation Fee	156,971
37. Other	0
40. Total Expenses	2,842,384
41. Income Before Income Taxes	-29,972
42. Income Taxes	0
43. Net Income or Loss for the Year	-29,972