

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0056408

Facility Name: Vandalia Rehab Health Care C

Address: 1500 W St Louis Ave Vandalia 62471
Number City Zip Code

County: Fayette

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid
Preparer

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

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

Facility Name & ID Number Vandalia Rehab Health Care C

0056408 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	116	TOTALS	116	42,340	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>375</u>	<u>3,294</u>	<u>3,669</u>	8
9	SNF/PED					9
10	ICF	<u>14,580</u>			<u>14,580</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,580	375	3,294	18,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.10%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve 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 3,282

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Vandalia Rehab Health Care C # 0056408 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	167,690	19,890	4,523	192,103		192,103	4,859	196,962			1
2	Food Purchase		161,552		161,552		161,552	(5,244)	156,308			2
3	Housekeeping	130,618	53,692		184,310		184,310	94	184,404			3
4	Laundry	7,752	16,936		24,688		24,688		24,688			4
5	Heat and Other Utilities			87,884	87,884		87,884	332	88,216			5
6	Maintenance	47,595	8,360	34,848	90,803		90,803	2,918	93,721			6
7	Other (specify):*											7
8	TOTAL General Services	353,655	260,430	127,255	741,340		741,340	2,959	744,299			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,073,181	127,984	21,875	1,223,040		1,223,040	1,566	1,224,606			10
10a	Therapy			246,881	246,881		246,881		246,881			10a
11	Activities	52,000	1,290		53,290		53,290	1,468	54,758			11
12	Social Services	26,260	212		26,472		26,472		26,472			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,151,441	129,486	286,756	1,567,683		1,567,683	3,034	1,570,717			16
	C. General Administration											
17	Administrative	68,496		202,100	270,596		270,596	(175,077)	95,519			17
18	Directors Fees											18
19	Professional Services			9,268	9,268		9,268	16,612	25,880			19
20	Dues, Fees, Subscriptions & Promotions			3,151	3,151		3,151	2,488	5,639			20
21	Clerical & General Office Expenses	32,883	3,294	25,658	61,835		61,835	30,089	91,924			21
22	Employee Benefits & Payroll Taxes			183,431	183,431		183,431	8,271	191,702			22
23	Inservice Training & Education							50	50			23
24	Travel and Seminar							16	16			24
25	Other Admin. Staff Transportation			5,359	5,359		5,359	3,481	8,840			25
26	Insurance-Prop.Liab.Malpractice			50,414	50,414		50,414	531	50,945			26
27	Other (specify):*											27
28	TOTAL General Administration	101,379	3,294	479,381	584,054		584,054	(113,539)	470,515			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,606,475	393,210	893,392	2,893,077		2,893,077	(107,546)	2,785,531			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			6,168	6,168		6,168	52,384	58,552			30
31	Amortization of Pre-Op. & Org.							13,360	13,360			31
32	Interest			8,069	8,069		8,069	66,953	75,022			32
33	Real Estate Taxes			40,160	40,160		40,160	191	40,351			33
34	Rent-Facility & Grounds			93,989	93,989		93,989	(93,989)				34
35	Rent-Equipment & Vehicles			85,612	85,612		85,612	1,764	87,376			35
36	Other (specify):*											36
37	TOTAL Ownership			233,998	233,998		233,998	40,663	274,661			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,735		73,735		73,735		73,735			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,188	154,188		154,188		154,188			42
43	Other (specify):*		132	64,769	64,901		64,901	(64,901)				43
44	TOTAL Special Cost Centers		73,867	218,957	292,824		292,824	(64,901)	227,923			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,606,475	467,077	1,346,347	3,419,899		3,419,899	(131,784)	3,288,115			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	(5,244)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,679)	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	(2,800)	30		9
10	Interest and Other Investment Income	(357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(354)	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	(21,712)	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	(19,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,261)	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	(18,454)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,861)		\$	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)	(56,923)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (56,923)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (131,784)		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	\$ (9,423)	43	1
2	X-Rays-Part A	(6,456)	43	2
3	Offset Transportation Revenue	1,468	11	3
4	Offset Miscellaneous Office Supplies Revenue	(40)	21	4
5	Disallowed Special Events	31	43	5
6	Offset Cable TV	(1,047)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(2,987)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(18,454)		49

Facility Name & ID Number	Vandalia Rehab Health Care C	#	0056408	Report Period Beginning:	1/1/2020	Ending:	12/31/2020
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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.

☒	X YES	☐	NO
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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%	\$ 4,859	\$ 4,859	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	94	94	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	332	332	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,918	2,918	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%	4,553	4,553	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	202,100	Petersen Health Care Management, Inc.	100.00%	27,023	(175,077)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	15,962	15,962	12
13	V								13
14	Total			\$ 202,100			\$ 55,741	\$ * (146,359)	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%	\$ 2,488	\$ 2,488	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	30,129	30,129	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	8,271	8,271	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	50	50	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	16	16	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,481	3,481	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	531	531	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,919	4,919	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	240	240	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	191	191	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,764	1,764	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			\$			\$ 52,080	\$ * 52,080	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 Wellness, LLC	100.00%	\$	\$	15
16	V	2	Food		Petersen Health Wellness, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Wellness, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Wellness, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Wellness, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Wellness, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Wellness, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Wellness, LLC	100.00%	650	650	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Wellness, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Wellness, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Wellness, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Wellness, LLC	100.00%			33
34	V	31	Amortization		Petersen Health Wellness, LLC	100.00%			34
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	181	181	35
36	V	33	Real Estate Taxes		Petersen Health Wellness, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%			38
39	Total			\$			\$ 831	\$ * 831	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	6	Maintenance	\$	Vandalia Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Vandalia Land, LLC	100.00%			16
17	V	21	Equipment		Vandalia Land, LLC	100.00%			17
18	V	26	Insurance-Property		Vandalia Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Vandalia Land, LLC	100.00%			19
20	V	30	Depreciation		Vandalia Land, LLC	100.00%	50,265	50,265	20
21	V	31	Amortization		Vandalia Land, LLC	100.00%	13,360	13,360	21
22	V	32	Interest		Vandalia Land, LLC	100.00%	66,889	66,889	22
23	V	33	Real Estate Taxes		Vandalia Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	93,989	Vandalia Land, LLC	100.00%		(93,989)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 93,989			\$ 130,514	\$ * 36,525	39

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

Facility Name & ID Number

Vandalia Rehab Health Care C

0056408

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Health Care C

0056408

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Health Care C

0056408

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

Facility Name & ID Number

Vandalia Rehab Health Care C

0056408

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Betty's Garden	Kewanee				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 Health Care C # 0056408 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Health Care C# 0056408

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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	\$ 341,562	\$ 398,718	18,249	\$ 4,859	1
2	2	Food	Resident Days	75	0	0	18,249	0	2
3	3	Housekeeping	Resident Days	75	6,607	3,056	18,249	94	3
4	5	Utilities	Resident Days	75	23,320	0	18,249	332	4
5	6	Maintenance	Resident Days	75	205,132	187,746	18,249	2,918	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,249	0	6
7	9	Medical Director	Resident Days	75	0	0	18,249	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,057	736,064	18,249	4,553	8
9	10A	Therapy	Resident Days	75	0	0	18,249	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,249	0	10
11	17	Administrative	Resident Days	75	1,899,565	7,673,667	18,249	27,023	11
12	19	Professional Services	Resident Days	75	1,122,028	0	18,249	15,962	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,863	0	18,249	2,488	13
14	21	Clerical and General Office	Resident Days	75	2,117,880	2,195,755	18,249	30,129	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,393	0	18,249	8,271	15
16	23	Inservice Training & Education	Resident Days	75	3,513	0	18,249	50	16
17	24	Travel and Seminar	Resident Days	75	1,094	0	18,249	16	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,700	0	18,249	3,481	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,297	0	18,249	531	19
20	30	Depreciation	Resident Days	75	345,756	0	18,249	4,919	20
21	31	Amortization	Resident Days	75	0	0	18,249	0	21
22	32	Interest	Resident Days	75	16,842	0	18,249	240	22
23	33	Real Estate Taxes	Resident Days	75	13,451	0	18,249	191	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,017	0	18,249	1,764	24
25	TOTALS				\$ 7,579,077	\$ 11,195,006		\$ 107,821	25

Facility Name & ID Number Vandalia Rehab Health Care C# 0056408

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	65,205	8	\$	\$	10,947	\$	1
2	2	Food	Resident Days	65,205	8			10,947		2
3	3	Housekeeping	Resident Days	65,205	8			10,947		3
4	4	Laundry	Resident Days	65,205	8			10,947		4
5	5	Utilities	Resident Days	65,205	8			10,947		5
6	6	Maintenance	Resident Days	65,205	8			10,947		6
7	7	Mgmt. Allocation of Benefits	Resident Days	65,205	8			10,947		7
8	10	Nursing and Medical Records	Resident Days	65,205	8			10,947		8
9	15	Mgmt. Allocation of Benefits	Resident Days	65,205	8			10,947		9
10	17	Administrative	Resident Days	65,205	8			10,947		10
11	19	Professional Services	Resident Days	65,205	8	3,870		10,947	650	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	65,205	8			10,947		12
13	21	Clerical and General Office	Resident Days	65,205	8			10,947		13
14	22	Employee Benefits & Payroll	Resident Days	65,205	8			10,947		14
15	23	Inservice Training & Education	Resident Days	65,205	8			10,947		15
16	24	Travel and Seminar	Resident Days	65,205	8			10,947		16
17	25	Other Admin. Staff Transport.	Resident Days	65,205	8			10,947		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	65,205	8			10,947		18
19	30	Depreciation	Resident Days	65,205	8			10,947		19
20	31	Amortization	Resident Days	65,205	8			10,947		20
21	32	Interest	Resident Days	65,205	8	1,079		10,947	181	21
22	33	Real Estate Taxes	Resident Days	65,205	8			10,947		22
23	34	Rent-Facility and Grounds	Resident Days	65,205	8			10,947		23
24	35	Rent-Equipment & Vehicles	Resident Days	65,205	8			10,947		24
25	TOTALS					\$ 4,949	\$		\$ 831	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	\$ Paid			\$ 7,154	1
2	Sector		X	Mortgage	Varies	4/1/2020	711,468	711,468	3/31/2023	Varies	66,889	2
3	Dodge		X	Auto Van	Varies	5/26/20	48,780	44,310	5/25/25	Varies	915	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,607,096	\$ 755,778			\$ 74,958	9
	B. Non-Facility Related*											
10								Interest Income Offset			(357)	10
11								Home Office Allocation-PHCM			240	11
12								Home Office Allocation-PHW			181	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 64	14
15	TOTALS (line 9+line14)						\$ 2,607,096	\$ 755,778			\$ 75,022	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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	42,264	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.)			\$	40,604	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,660)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	41,820	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Home Office Allocation	\$	191	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	40,351	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	41,132	8	
		2016	42,595	9	
		2017	41,992	10	
		2018	41,027	11	
		2019	40,604	12	
Accrual based on prior year tax bill.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Vandalia Rehabilitation & Health Care Center 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 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-14-17-453-012</u>	<u>Long-Term Care Facility</u>	\$ <u>40,604.34</u>	\$ <u>40,604.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>40,604.34</u></u>	\$ <u><u>40,604.34</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A	

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

1. Total Amount Incurred: 35,625 2. Number of Years Over Which it is Being Amortized: 3
3. Current Period Amortization: 13,360 4. Dates Incurred: 2020

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

Facility Name & ID Number Vandalia Rehab Health Care C

0056408

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		2005	1969	\$ 527,250	\$	25	\$ 21,090	\$ 21,090	\$ 326,895	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	13,000		15	867	867	12,571	9
10	Water Heater			2007	7,681		15	512	512	6,912	10
11	Air Conditioner			2007	5,800		15	387	387	5,224	11
12	Carpeting			2007	4,617		10			4,617	12
13	Electrical Panel Repair			2008	2,600		7			2,600	13
14	Heating Unit-Dining Room			2009	3,150		5			3,150	14
15	Sprinkler System Replacement			2010	5,850		7			5,850	15
16	Sprinkler System Replacement-Completion of 2010			2011	42,840		15	2,856	2,856	27,132	16
17	Sprinkler System Repair			2011	13,713		7			13,713	17
18	Sewer Line Repair			2011	3,365		7			3,365	18
19	Sprinkler Leak Repair			2011	4,885		7			4,885	19
20	Water Leak Repair			2011	2,531		7			2,531	20
21	Sewer Line Repair			2011	3,219		7			3,219	21
22	Smoke Detector Installation			2012	2,907		10	290	290	2,465	22
23	Bathroom Fixtures			2013	4,399		7	317	317	4,399	23
24	Water Pipe Repair			2013	7,571		7	538	538	7,571	24
25	Entrance to Building			2014	3,734		7	534	534	3,471	25
26	Panic Bar			2014	2,776		7	397	397	2,581	26
27	Carpet and Ceramic Tile in Halls, Walls, Dining Room			2014	16,850		15	562	562	3,653	27
28	Electrical Power Feeds			2014	3,875		15	258	258	1,677	28
29	Deck, Ramp and Rail Replacement			2014	11,799		15	787	787	5,115	29
30	Roof Repairs			2014	26,018		15	1,736	1,736	6,944	30
31	Sprinkler Line Repair			2016	2,964		7	424	424	1,908	31
32	Sewer Line Repair			2016	6,450		7	922	922	4,149	32
33	Freezer Repair			2017	2,990		7	428	428	1,498	33
34	Furance and Air Conditioner			2017	5,100		15	340	340	1,190	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

Facility Name & ID Number Vandalia Rehab Health Care C

0056408

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	Water Pipe Repair	2018	\$ 2,783	\$	7	\$ 398	\$ 398	\$ 995	37
38	Water Heater	2018	4,545		7	650	650	1,625	38
39	Water Line Repair	2018	5,950		5	1,190	1,190	3,570	39
40	Water Line Repairs	2019	4,250		7	608	608	912	40
41	Plumbing Repair	2020	6,680		7	477	477	477	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	Land Improvements Booked			1,181			(1,181)		57
58	Building Booked			21,155			(21,155)		58
59	Building Improvement Booked			14,215			(14,215)		59
60									60
61	2020-Home Office Allocation-Building Improvements		9,227			221	221		61
62	2020-Home Office Allocation-Land Improvements		926			59	59		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 772,295	\$ 36,551		\$ 36,848	\$ 297	\$ 476,864	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	\$102,074	\$13,167	\$11,419	\$(1,748)	5-10 yrs.	\$57,995	71
72	Current Year Purchases	10,744	1,024	768	(256)	7 yrs.	768	72
73	Fully Depreciated Assets	161,901					161,901	73
74	Home Office Allocation			4,639	4,639			74
75	TOTALS	\$274,719	\$14,191	\$16,826	\$2,635		\$220,664	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	Facility	2018 Dodge Pro Van	2020	\$48,780	\$5,691	\$4,878	\$(813)	5 yrs.	\$4,878
77									
78									
79									
80	TOTALS			\$48,780	\$5,691	\$4,878	\$(813)		\$4,878

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)			\$	1,125,044
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	56,433
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	58,552
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	2,119
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	702,406

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		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 87,376 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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 Health Care C
0056408

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	78,698
Dishwasher		701
Copier		6,213
Home Office Allocation		1,764
		<u>87,376</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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,724	\$ 85,858	\$	5,724	\$ 85,858	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,445	51,673		3,445	51,673	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,290	109,350		7,290	109,350	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				73,735		73,735	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	16,459	\$ 246,881	\$ 73,735	16,459	\$ 320,616	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	\$ (24,838)	\$ (24,838)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,131)	1,538,843	1,538,843	3
4	Supply Inventory (priced at Cost)	10,381	10,381	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,742	28,742	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		2,620	8
9	Other(specify): Employee Advances	550	550	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,553,678	\$ 1,556,298	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		29,250	13
14	Buildings, at Historical Cost		536,477	14
15	Leasehold Improvements, at Historical Cost	6,680	235,818	15
16	Equipment, at Historical Cost	48,780	323,499	16
17	Accumulated Depreciation (book methods)	(6,168)	(702,406)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		22,265	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	172,163	226,686	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	746,692	796,064	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 968,147	\$ 1,467,653	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,521,825	\$ 3,023,951	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 810,150	\$ 810,150	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,452	67,452	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,820	41,820	32
33	Accrued Interest Payable		8,532	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	85,753	85,753	36
37	Accrued Management Fees	31,009	31,009	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,036,184	\$ 1,044,716	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,310	44,310	39
40	Mortgage Payable		711,468	40
41	Bonds Payable			41
42	Deferred Compensation	66,594	66,594	42
	Other Long-Term Liabilities(specify):			
43	Notes Payable-SBA PPP	291,300	291,300	43
44	Loan Payable-MCAD Adv. Payment	250,000	250,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 652,204	\$ 1,363,672	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,688,388	\$ 2,408,388	46
47	TOTAL EQUITY(page 18, line 24)	\$ 833,437	\$ 615,563	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,521,825	\$ 3,023,951	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,554,707)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,459,576	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (95,131)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	928,568	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)	\$ 928,568	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)	\$ 833,437	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Vandalia Rehab Health Care C

0056408

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 3,502,820	1
2	Discounts and Allowances for all Levels	(150,729)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,352,091	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	509,250	6
7	Oxygen	3,470	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 512,720	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	5,244	14
15	Telephone, Television and Radio	1,047	15
16	Rental of Facility Space		16
17	Sale of Drugs	111,972	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,065	20
21	Other Medical Services	36,353	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,681	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	357	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 357	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	(1,468)	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	310,086	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 308,618	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,348,467	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	741,340	31
32	Health Care	1,567,683	32
33	General Administration	584,054	33
	B. Capital Expense		
34	Ownership	233,998	34
	C. Ancillary Expense		
35	Special Cost Centers	138,636	35
36	Provider Participation Fee	154,188	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,419,899	40
41	Income before Income Taxes (line 30 minus line 40)**	928,568	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 928,568	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,997,328	44
45	Private Pay - Net Inpatient Revenue	57,421	45
46	Medicare - Net Inpatient Revenue	1,292,195	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	3,936	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,350,880	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	1,984	2,023	\$ 60,000	\$ 29.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,347	3,391	81,898	24.15	3
4	Licensed Practical Nurses	13,604	14,207	326,381	22.97	4
5	CNAs & Orderlies	41,386	42,386	537,558	12.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	2,016	20,820	10.33	9
10	Activity Assistants					10
11	Social Service Workers	2,125	2,167	26,260	12.12	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,858	17.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,236	12,493	131,832	10.55	15
16	Dishwashers					16
17	Maintenance Workers	2,042	2,171	47,595	21.92	17
18	Housekeepers	11,840	12,071	130,618	10.82	18
19	Laundry	795	815	7,752	9.51	19
20	Administrator	1,947	2,016	68,496	33.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	32,883	15.81	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	854	854	22,301	26.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) CPC	3,467	3,467	76,223	21.99	33
34	TOTAL (lines 1 - 33)	101,591	104,237	\$ 1,606,475 *	\$ 15.41	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	75	\$ 4,523	L1, C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,015	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	10	635	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Telehealth	3	157	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	88	\$ 29,330		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	59	\$ 2,065	L10,C3	50
51	Licensed Practical Nurses	230	7,459	L10,C3	51
52	Certified Nurse Assistants/Aides	243	5,544	L10,C3	52
53	TOTAL (lines 50 - 52)	532	\$ 15,068		53

Vandalia Rehab Health Care C
0056408
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		1,387	1,387	32.48
Transportation		2,080	2,080	14.99
	TOTAL	3,467	3,467	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	% Ownership	Amount		
Shannon Tate	Administrator	0	\$ 68,496		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,496		
B. Administrative - Other					
Description			Amount		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 202,100		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 202,100		
C. Professional Services					
Vendor/Payee	Type		Amount		
Ability Network	Computer Services		\$ 7,118		
New Wave Communications	Computer Services		2,028		
Sector Bank	Title Lien Search-July		122		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 9,268		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 28,089		
Unemployment Compensation Insurance			24,076		
FICA Taxes			114,567		
Employee Health Insurance			3,452		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Employee Relations			143		
Home Office Allocation			8,271		
Administrator Benefits			13,104		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 191,702		
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			\$ 1,990		
Advertising: Employee Recruitment					
Health Care Worker Background Check (Indicate # of checks performed)		16			
Patient Background Checks		18	543		
Miscellaneous Licenses & Permits			618		
Home Office Allocation			2,488		
Less: Public Relations Expense			()		
Non-allowable advertising			()		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 5,639		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense					
Home Office Allocation			16		
Entertainment Expense			()		
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 16		

*** Attach copy of IMRF notifications**

****See instructions.**

**Vandalia Rehab Health Care C
0056408**

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,268

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	281
Duane Morris	Legal	393
Lexis Nexis	Legal	8
Livingston, Barger, Brant, Schroeder	Legal	15
Miller, Hall, Triggs	Legal	49
Miscellaneous	Legal	18
SB2	Legal	145
SmithAmundsen LLC	Legal	898
Sorling Northrup	Legal	256
Illinois Secretary of Sate	Legal	176
CliftonLarsonAllen	Accounting	1,116
Ginoli & Co.	Accounting	1,269
Ability Network	Computer Services	2,865
Allscripts	Computer Services	452
AOD Matrix Care	Computer Services	5,031
AT&T	Computer Services	5
ATS	Computer Services	274
CCH	Computer Services	16
Charter Communications	Computer Services	25
Citrix Systems	Computer Services	85
Comcast	Computer Services	29
ITSavvy	Computer Services	132
Kemper Technology	Computer Services	654
Miscellaneous	Computer Services	127
Pearl Technology	Computer Services	118
Stratus Networks	Computer Services	519
TR Professional	Computer Services	11
David Budde	Other Prof Fees	11
DJ Howard and Associates	Other Prof Fees	22
Getzler Henrich & Associates	Other Prof Fees	89
LRI Consulting Services	Other Prof Fees	86
McQuellon Consulting	Other Prof Fees	54
Miscellaneous	Other Prof Fees	106
Optimizer	Other Prof Fees	47
Registered Agent Solutions	Other Prof Fees	26
RSM McGladrey	Other Prof Fees	284
SB2	Other Prof Fees	363
Sedgwick CMS	Other Prof Fees	489
Tarver Program Consultants	Other Prof Fees	68

Total (agree to Schedule V, line 19, column 8)	<u><u>25,880</u></u>
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Vandalia Rehab Health Care C
0056408

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	2,803
Auto Repairs		2,556
Mileage-Travel		-
Home Office Allocation		<u>3,481</u>
		<u><u>8,840</u></u>

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? No
If YES, give association name and amount. _____

(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? 7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,063 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 154,188
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. \$ 5,244

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(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 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. No
Attach invoices and a summary of services for all architect and appraisal fees.