

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

<p>I. IDPH License ID Number: <u>0052290</u></p> <p>Facility Name: <u>Mt Vernon Health Care Center</u></p> <p>Address: <u>5 Doctors Park Road</u> <u>Mount Vernon</u> <u>62864</u> Number City Zip Code</p> <p>County: <u>Jefferson</u></p> <p>Telephone Number: <u>(618) 242-1064</u> Fax # <u>(618) 242-7559</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/1/2006</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2015</u> to <u>12/31/2015</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) <u>()</u> Fax # <u>()</u>																																									
<p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<p>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</p>																																									

Facility Name & ID Number Mt Vernon Health Care Center

0052290 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,690	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	25,467	5,540		31,007
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	25,467	5,540		31,007

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.14%

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 3/10/2006

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	142,592	13,189	2,018	157,799		157,799	6,009	163,808		1
2	Food Purchase		189,469		189,469		189,469	(65)	189,404		2
3	Housekeeping	203,397	36,228		239,625		239,625	47	239,672		3
4	Laundry	1,512	6,391		7,903		7,903		7,903		4
5	Heat and Other Utilities			68,891	68,891		68,891	346	69,237		5
6	Maintenance	47,174	4,780	16,850	68,804		68,804	2,383	71,187		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	394,675	250,057	87,759	732,491		732,491	8,720	741,211		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,309,405	86,182	6,828	1,402,415		1,402,415	9	1,402,424		10
10a	Therapy										10a
11	Activities	47,179			47,179		47,179	(5,504)	41,675		11
12	Social Services	29,065			29,065		29,065		29,065		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	1,385,649	86,182	12,828	1,484,659		1,484,659	(5,495)	1,479,164		16
	C. General Administration										
17	Administrative			252,000	252,000		252,000	(190,625)	61,375		17
18	Directors Fees										18
19	Professional Services			6,990	6,990		6,990	28,872	35,862		19
20	Dues, Fees, Subscriptions & Promotions			6,368	6,368		6,368	6,054	12,422		20
21	Clerical & General Office Expenses	34,097	1,024	9,801	44,922		44,922	67,220	112,142		21
22	Employee Benefits & Payroll Taxes			248,529	248,529		248,529	45,054	293,583		22
23	Inservice Training & Education							463	463		23
24	Travel and Seminar							105	105		24
25	Other Admin. Staff Transportation			5,880	5,880		5,880	4,729	10,609		25
26	Insurance-Prop.Liab.Malpractice			2,810	2,810		2,810	42,990	45,800		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	34,097	1,024	532,378	567,499		567,499	4,862	572,361		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,814,421	337,263	632,965	2,784,649		2,784,649	8,087	2,792,736		29

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

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

Facility Name & ID Number Mt Vernon Health Care Center

#0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			4,193	4,193	4,193	52,279	56,472				30
31	Amortization of Pre-Op. & Org.						7,768	7,768				31
32	Interest						110,568	110,568				32
33	Real Estate Taxes						21,023	21,023				33
34	Rent-Facility & Grounds			285,680	285,680	285,680	(285,680)					34
35	Rent-Equipment & Vehicles			19,851	19,851	19,851	912	20,763				35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			309,724	309,724	309,724	(93,130)	216,594				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105		105	105		105				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,301	245,301	245,301		245,301				42
43	Other (specify):* Home Office Ben. Allocati			36,298	36,298	36,298	(36,298)					43
44	TOTAL Special Cost Centers		105	281,599	281,704	281,704	(36,298)	245,406				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,814,421	337,368	1,224,288	3,376,077	3,376,077	(121,341)	3,254,736				45

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

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(75)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,769)	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	(21,339)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12)	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	(27,187)	43		18
19	Entertainment				19
20	Contributions	(250)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,080)	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	(6,227)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,939)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(57,402)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (57,402)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (121,341)		37

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

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

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

Mt Vernon Health Care Center

ID# 0052290

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Office Supplies Revenue	(149)	21	1
2	Offset Miscellaneous Nursing Supplies Revenue	(174)	21	2
3	Offset Transportation Revenue	(5,504)	11	3
4	Disallowed Chamber of Commerce Dues	(400)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(6,227)	49

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5	
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	302	302	12	
13	V							13	
14	Total		\$			\$ 302	\$ *	302	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 81	\$	81	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,175		1,175	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			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		\$			\$ 1,256	\$ *	1,256	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 Management Company, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Management Company, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Management Company, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Management Company, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Management Company, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Management Company, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Management Company, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Management Company, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Management Company, LLC	100.00%	11,627	11,627	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	6,183	6,183	26
27	V	21 Clerical and General Office		Petersen Management Company, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Management Company, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Management Company, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Management Company, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Management Company, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Management Company, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Management Company, LLC	100.00%	877	877	33
34	V	31 Amortization		Petersen Management Company, LLC	100.00%	3,429	3,429	34
35	V	32 Interest		Petersen Management Company, LLC	100.00%	42,408	42,408	35
36	V	33 Real Estate Taxes		Petersen Management Company, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Management Company, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Management Company, LLC	100.00%	0		38
39	Total		\$			\$ 64,524	\$ * 64,524	39

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

Facility Name & ID Number Mt Vernon Health Care Center# 0052290Report Period Beginning: 1/1/2015Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 6,009	\$ 6,009
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	10	10
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	47	47
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	346	346
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,383	2,383
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	183	183
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	252,000	Petersen Health Care Management, Inc.	100.00%	61,375	(190,625)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	10,629	10,629
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	190	190
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	67,369	67,369
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	45,054	45,054
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	463	463
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	105	105
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,729	4,729
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	726	726
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	10,792	10,792
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	348	348
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	788	788
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	912	912
39	Total		\$ 252,000			\$ 212,458	\$ * (39,542)

* 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	19 Professional Fees	\$	Petersen 29, LLC	100.00%	\$ 6,314	\$ 6,314
16	V	26 Insurance-Property		Petersen 29, LLC	100.00%	29,100	29,100
17	V	26 Insurance-MIP		Petersen 29, LLC	100.00%	13,164	13,164
18	V	30 Depreciation		Petersen 29, LLC	100.00%	60,774	60,774
19	V	31 Amortization		Petersen 29, LLC	100.00%	4,339	4,339
20	V	32 Interest		Petersen 29, LLC	100.00%	67,812	67,812
21	V	33 Real Estate Taxes		Petersen 29, LLC	100.00%	20,235	20,235
22	V	34 Rent-Facility and Grounds	285,680	Petersen 29, LLC	100.00%		(285,680)
23	V				100.00%		
24	V				100.00%		
25	V				100.00%		
26	V				100.00%		
27	V				100.00%		
28	V				100.00%		
29	V				100.00%		
30	V				100.00%		
31	V				100.00%		
32	V				100.00%		
33	V				100.00%		
34	V				100.00%		
35	V				100.00%		
36	V				100.00%		
37	V				100.00%		
38	V				100.00%		
39	Total		\$ 285,680			\$ 201,738	\$ * (83,942)

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

Facility Name & ID Number

Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 0	\$ 0	31,007	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	31,007	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	31,007	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	31,007	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	31,007	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	31,007	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	31,007	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	31,007	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	31,007	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	31,007	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	31,007	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	31,007	302	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	31,007	81	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	31,007	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	31,007	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	31,007	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	31,007	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	31,007	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	31,007	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	31,007	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	31,007	1,175	21
22	32	Interest	Resident Days	1,553,881	75	0	0	31,007	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	31,007	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	31,007	0	24
25	TOTALS					\$ 78,110	\$		\$ 1,558	25

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	172,530	6		31,007		1
2	2	Food	Resident Days	172,530	6		31,007		2
3	3	Housekeeping	Resident Days	172,530	6		31,007		3
4	4	Laundry	Resident Days	172,530	6		31,007		4
5	5	Utilities	Resident Days	172,530	6		31,007		5
6	6	Maintenance	Resident Days	172,530	6		31,007		6
7	7	Mgmt. Allocation of Benefits	Resident Days	172,530	6		31,007		7
8	10	Nursing and Medical Records	Resident Days	172,530	6		31,007		8
9	15	Mgmt. Allocation of Benefits	Resident Days	172,530	6		31,007		9
10	17	Administrative	Resident Days	172,530	6		31,007		10
11	19	Professional Services	Resident Days	172,530	6	64,696	31,007	11,627	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	172,530	6	34,401	31,007	6,183	12
13	21	Clerical and General Office	Resident Days	172,530	6		31,007		13
14	22	Employee Benefits & Payroll	Resident Days	172,530	6		31,007		14
15	23	Inservice Training & Education	Resident Days	172,530	6		31,007		15
16	24	Travel and Seminar	Resident Days	172,530	6		31,007		16
17	25	Other Admin. Staff Transport.	Resident Days	172,530	6		31,007		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	172,530	6		31,007		18
19	30	Depreciation	Resident Days	172,530	6	4,880	31,007	877	19
20	31	Amortization	Resident Days	172,530	6	19,078	31,007	3,429	20
21	32	Interest	Resident Days	172,530	6	235,965	31,007	42,408	21
22	33	Real Estate Taxes	Resident Days	172,530	6		31,007		22
23	34	Rent-Facility and Grounds	Resident Days	172,530	6		31,007		23
24	35	Rent-Equipment & Vehicles	Resident Days	172,530	6		31,007		24
25	TOTALS					\$ 359,020	\$	\$ 7,030	25

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 301,135	\$ 292,840	31,007	\$ 6,009	1
2	2	Food	Resident Days	1,553,881	75	480		31,007	10	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	31,007	47	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		31,007	346	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	31,007	2,383	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			31,007		6
7	9	Medical Director	Resident Days	1,553,881	75			31,007		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		31,007	183	8
9	10A	Therapy	Resident Days	1,553,881	75			31,007		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			31,007		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	31,007	61,375	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		31,007	10,629	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		31,007	190	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	31,007	67,369	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		31,007	45,054	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		31,007	463	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		31,007	105	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		31,007	4,729	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		31,007	726	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			31,007		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		31,007	10,792	21
22	32	Interest	Resident Days	1,553,881	75	17,439		31,007	348	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		31,007	788	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		31,007	912	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 212,458	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	1st Merit		X	HUD Mortgage	Varies	5/1/13	2,146,000	\$ 1,998,463	4/30/38	Varies	\$ 68,462	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 2,146,000	\$ 1,998,463			\$ 68,462	9					
B. Non-Facility Related*																	
10												10					
11											(650)	11					
12											42,408	12					
13											348	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 42,106	14					
15	TOTALS (line 9+line14)						\$ 2,146,000	\$ 1,998,463			\$ 110,568	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 13,164 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	21,864		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.)		\$	20,739		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,125)		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	21,360		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.				Home Office Allocation	788
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	21,023		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	18,505	8	FOR BHF USE ONLY	
	2011	20,009	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	20,530	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	21,224	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	20,739	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Accrual based on prior year tax bill.					

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mt Vernon Health Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0052290

CONTACT PERSON REGARDING THIS REPORT MARK PETERSEN

TELEPHONE (309)691-8113 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-36-126-015</u>	<u>Long-Term Care Facility</u>	\$ <u>20,738.70</u>	\$ <u>20,738.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>20,738.70</u></u>	\$ <u><u>20,738.70</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Mt Vernon Health Care Center

0052290 Report Period Beginning:

1/1/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick 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: 108,486 2. Number of Years Over Which it is Being Amortized: 25
 3. Current Period Amortization: 7,768 4. Dates Incurred: May-December 2013

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	<u>Facility</u>		<u>120,000</u>	<u>2005</u>	<u>\$ 60,000</u>	1
2						2
3	TOTALS		120,000		\$ 60,000	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	106	2005	1970	\$ 1,190,500	\$	25	\$ 24,142	\$ 24,142	\$ 241,088	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements		2006	15,000		15	1,000	1,000	10,249	9
10	Durolast		2006	26,843		20	1,342	1,342	12,749	10
11	Sign front door		2006	3,118		20	156	156	1,482	11
12	Fire Alarm		2007	2,222		15	148	148	1,258	12
13	Roof Top Air Conditioner		2007	4,990		15	333	333	2,830	13
14	Sprinkler System		2008	86,980		39	2,230	2,230	16,725	14
15	Furnace		2008	6,600		5			6,600	15
16	Sewer Line Repair		2009	10,514		7	1,502	1,502	9,763	16
17	Sidewalks		2009	8,930		15	596	596	3,874	17
18	Nurses Station		2010	2,865		5	282	282	2,865	18
19	Backflow Preventer		2011	3,669		10	366	366	1,291	19
20	Water Heater		2011	3,745		10	374	374	1,683	20
21	Water Heater		2012	3,856		7	550	550	1,925	21
22	Roof Replacement		2014	97,480		25	3,900	3,900	5,850	22
23	Air conditioner		2014	7,305		15	487	487	731	23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,595			(1,595)		30
31	Building Booked				47,620			(47,620)		31
32	Building Improvement Booked				9,554			(9,554)		32
33										33
34	2015-Home Office Allocation-Building Improvements			13,567			325	325		34
35	2015-Home Office Allocation-Land Improvements			1,266			81	81		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 Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,489,450	\$ 58,769		\$ 37,814	\$ (20,955)	\$ 320,963	70

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

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$ 275,426	\$ 6,054	\$ 5,919	\$ (135)	5-10 yrs.	\$ 27,430	71
72	Current Year Purchases	6,034	144	301	157	10 yrs.	301	72
73	Fully Depreciated Assets	216,236					216,236	73
74	Home Office Allocation			12,438	12,438			74
75	TOTALS	\$ 497,696	\$ 6,198	\$ 18,658	\$ 12,460		\$ 243,967	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,047,146	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,967	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,472	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,495)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 564,930	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 12,506 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 688.00	\$ 8,257	17
18					18
19					19
20					20
21	TOTAL		\$ 688.00	\$ 8,257	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.

Mt Vernon Health Care Center

0052290

Period Beginning 1/1/2015

Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	596
Dishwasher		573
Copier		10,425
Home Office Allocation		<u>912</u>
		<u><u>12,506</u></u>

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$			\$					1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescrpts							105					105	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			\$		\$		\$		105		\$		105		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Mt Vernon Health Care Center# 0052290Report Period Beginning: 1/1/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 931,708	\$ 931,708	1
2	Cash-Patient Deposits	4,512	4,512	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>11,707</u>)	589,919	589,919	3
4	Supply Inventory (priced at <u>Cost</u>)	12,636	12,636	4
5	Short-Term Investments			5
6	Prepaid Insurance	32,165	39,941	6
7	Other Prepaid Expenses	47,224	47,224	7
8	Accounts Receivable (owners or related parties)		24,448	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,618,164	\$ 1,650,388	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,204,067	14
15	Leasehold Improvements, at Historical Cost	7,305	285,383	15
16	Equipment, at Historical Cost	30,966	497,696	16
17	Accumulated Depreciation (book methods)	(7,631)	(564,930)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		108,486	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(11,572)	20
21	Restricted Funds		734,962	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 30,640	\$ 2,314,092	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,648,804	\$ 3,964,480	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 324,231	\$ 428,025	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,997	109,997	30
31	Accrued Taxes Payable (excluding real estate taxes)	255,055	255,055	31
32	Accrued Real Estate Taxes(Sch.IX-B)		21,360	32
33	Accrued Interest Payable		5,629	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	4,417	4,417	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 693,700	\$ 824,483	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,998,463	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	728,260	163,776	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 728,260	\$ 2,162,239	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,421,960	\$ 2,986,722	46
47	TOTAL EQUITY(page 18, line 24)	\$ 226,844	\$ 977,758	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,648,804	\$ 3,964,480	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,449)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Entered After Cost Reports Were Filed	2,148	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,301)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	229,145	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)	\$ 229,145	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)	\$ 226,844	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,599,320	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,599,320	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	75	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 75	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	5,504	28
28a	Miscellaneous Revenue	323	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,827	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,605,222	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	732,491	31
32	Health Care	1,484,659	32
33	General Administration	567,499	33
B. Capital Expense			
34	Ownership	309,724	34
C. Ancillary Expense			
35	Special Cost Centers	36,403	35
36	Provider Participation Fee	245,301	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,376,077	40
41	Income before Income Taxes (line 30 minus line 40)**	229,145	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 229,145	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,953,454	44
45	Private Pay - Net Inpatient Revenue	645,866	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,599,320	49

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

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

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

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

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$ 57,806	\$ 27.79	1
2	Assistant Director of Nursing	2,080	2,080	48,787	23.46	2
3	Registered Nurses	12,506	12,851	274,027	21.32	3
4	Licensed Practical Nurses	10,533	10,852	185,385	17.08	4
5	CNAs & Orderlies	61,952	63,595	640,900	10.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,945	2,072	25,668	12.39	9
10	Activity Assistants	1,948	2,068	21,511	10.40	10
11	Social Service Workers	2,076	2,076	29,065	14.00	11
12	Dietician					12
13	Food Service Supervisor	2,071	2,071	32,239	15.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,870	13,081	110,353	8.44	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	47,174	22.68	17
18	Housekeepers	21,801	22,509	203,397	9.04	18
19	Laundry	195	195	1,512	7.75	19
20	Administrator	2,080	2,080	61,375	29.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,300	2,463	34,097	13.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,080	2,080	50,976	24.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	682	682	6,815	9.99	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Alzheimer's Coord</u>	2,080	2,080	44,709	21.49	33
34	TOTAL (lines 1 - 33)	143,359	146,995	\$ 1,875,796 *	\$ 12.76	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	40	\$ 2,018	L1, C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,699	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	\$ 14,717		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Jeremy Biggerstaff</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 61,375</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 54,267</u>	<u>IDPH License Fee</u>	<u>\$ 3,980</u>	
				<u>Unemployment Compensation Insurance</u>	<u>56,965</u>	<u>Advertising: Employee Recruitment</u>	<u>728</u>	
				<u>FICA Taxes</u>	<u>137,033</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>(1,014)</u>	<u>(Indicate # of checks performed <u>99</u>)</u>	<u>1,085</u>	
				<u>Employee Meals</u>		<u>Miscellaneous Licenses & Permits</u>	<u>175</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues & Subscriptions</u>	<u>400</u>	
				<u>Employee Relations</u>	<u>700</u>	<u>Home Office Allocation</u>	<u>6,454</u>	
				<u>Employee Retirement</u>	<u>578</u>			
				<u>Home Office Allocation</u>	<u>45,054</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 61,375	TOTAL (agree to Schedule V, line 22, col.8)			\$ 293,583	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			<u>\$ 252,000</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 252,000				<u>Seminar Expense</u>	
(Attach a copy of any management service agreement)							<u>Home Office Allocation</u>	<u>105</u>
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type	Amount						
<u>Charter Communications</u>	<u>Computer Services</u>	<u>\$ 840</u>						
<u>Honkamp, Kruger, & Co.</u>	<u>Accounting Services</u>	<u>2,987</u>						
<u>E-Health Data Solutions</u>	<u>Computer Services</u>	<u>3,051</u>						
<u>Franklin County Circuit Clerk</u>	<u>Filing Fees</u>	<u>112</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 6,990	\$			\$ 105	
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Mt Vernon Health Care Center
0052290
Period Beginning
Period End

1/1/2015
12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,990
Home Office Allocation		
Denton's US LLP	Legal	151
Applegate and Thorne	Legal	23
Miller Hall and Triggs	Legal	23
Healthcare Resources International	Legal	124
Lexis Nexis	Legal	9
GoffWilson	Legal	1034
First Merit	Legal	250
CliftonLarson Allen	Accountants	1,614
Ginoli & Co.	Accountants	7,366
Miscellaneous	Computer Services	68
CCH	Computer Services	18
PTC Select	Computer Services	25
Advanced Answers on Demand	Computer Services	3309
Stratus Networks	Computer Services	602
Kemper Technology	Computer Services	885
AT&T	Computer Services	8
Ability Network	Computer Services	852
CIAN	Computer Services	600
Comcast	Computer Services	23
Emdeon	Computer Services	50
Charter Communications	Computer Services	41
Allscripts	Computer Services	721
Allpayer Exchange	Computer Services	19
E-Health Technologies	Computer Services	13
Macquarie Technology Services	Computer Services	20

Optimizer	Other Prof Fees	58
D.J. Howard Appraisers	Other Prof Fees	53
Key Corporate Services	Other Prof Fees	176
Consolidated Land Surveying	Other Prof Fees	111
Alan Litwiller	Other Prof Fees	23
Marotta Gund Budd & Derza	Other Prof Fees	10603

Total (agree to Schedule V, line 19, column 8)		<u><u>35,862</u></u>
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

Facility Name & ID Number Mt Vernon Health Care Center

0052290

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,281 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. \$ 245,301
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. \$ 75
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 5,504
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.