		FOR BHF USE			

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

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

I. IDPH License ID Number: 0052290

Facility Name: Mt Vernon Health Care Center

Address: 5 Doctors Park Road (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-1064 **Fax #** (618) 242-7559

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 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 B. 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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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	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					8
9	SNF/PED					9
10	ICF	26,683	5,648		32,331	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,683	5,648		32,331	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.56%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ______ and days of care provided ______

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number: Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	144,019	16,135	1,757	161,911		161,911	6,641	168,552			1
2	Food Purchase		208,305		208,305		208,305	121	208,426			2
3	Housekeeping	174,567	31,490		206,057		206,057	116	206,173			3
4	Laundry	21,866	8,058		29,924		29,924		29,924			4
5	Heat and Other Utilities			67,489	67,489		67,489	387	67,876			5
6	Maintenance	52,308	9,193	15,310	76,811		76,811	5,140	81,951			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	392,760	273,181	84,556	750,497		750,497	12,405	762,902			8
	B. Health Care and Programs											
9	Medical Director			11,250	11,250		11,250		11,250			9
10	Nursing and Medical Records	1,530,424	81,742	7,189	1,619,355		1,619,355	(598)	1,618,757			10
10a	Therapy											10a
11	Activities	48,542	13	457	49,012		49,012	(4,311)	44,701			11
12	Social Services	25,817			25,817		25,817		25,817			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,604,783	81,755	18,896	1,705,434		1,705,434	(4,909)	1,700,525			16
	C. General Administration											
17	Administrative			286,400	286,400		286,400	(224,650)	61,750			17
18	Directors Fees											18
19	Professional Services			433	433		433	43,075	43,508			19
20	Dues, Fees, Subscriptions & Promotions			4,496	4,496		4,496	307	4,803			20
21	Clerical & General Office Expenses	30,573	3,136	11,018	44,727		44,727	77,296	122,023			21
22	Employee Benefits & Payroll Taxes			244,759	244,759		244,759	44,212	288,971			22
23	Inservice Training & Education							148	148			23
24	Travel and Seminar			162	162		162	72	234			24
25	Other Admin. Staff Transportation			5,991	5,991		5,991	6,091	12,082			25
26	Insurance-Prop.Liab.Malpractice			2,977	2,977		2,977	43,267	46,244			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	30,573	3,136	556,236	589,945		589,945	(10,182)	579,763			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,028,116	358,072	659,688	3,045,876		3,045,876	(2,686)	3,043,190			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: 1/1/2016 Ending: 12/31/2016

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,541	7,541		7,541	57,759	65,300			30
31	Amortization of Pre-Op. & Org.							4,339	4,339			31
32	Interest							116,363	116,363			32
33	Real Estate Taxes							21,726	21,726			33
34	Rent-Facility & Grounds			292,291	292,291		292,291	(292,291)				34
35	Rent-Equipment & Vehicles			31,323	31,323		31,323	1,393	32,716			35
36	Other (specify):*											36
37	TOTAL Ownership			331,155	331,155		331,155	(90,711)	240,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14		14		14		14			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,977	253,977		253,977		253,977			42
43	Other (specify):*		281	103,178	103,459		103,459	(103,459)				43
44	TOTAL Special Cost Centers		295	357,155	357,450		357,450	(103,459)	253,991			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,028,116	358,367	1,347,998	3,734,481		3,734,481	(196,856)	3,537,625			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: 1/1/2016 Ending: 12/31/2016

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				4
5	Telephone, TV & Radio in Resident Rooms	(7,761)	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	(21,246)	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				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	(24,357)	43		18
19	Entertainment				19
20	Contributions	(25)	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	(69,800)	43		24
25	Fund Raising, Advertising and Promotional	(1,819)	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	(5,328)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (130,336)		$	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)	(66,520)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (66,520)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (196,856)		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

Mt Vernon Health Care Center

ID# 0052290

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	(125)	21	1
2	Offset Miscellaneous Nursing Supplies Revenue	(795)	21	2
3	Offset Transportation Revenue	(4,311)	11	3
4	Disallowed Chamber of Commerce Dues	(400)	20	4
5	Labs-Part A	300	43	5
6	Disallowed Special Events	3	43	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
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	(5,328)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	6,641	0	0	0	0	0	0	0	0	0	6,641	1
2	Food Purchase	0	121	0	0	0	0	0	0	0	0	0	121	2
3	Housekeeping	0	116	0	0	0	0	0	0	0	0	0	116	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	387	0	0	0	0	0	0	0	0	0	387	5
6	Maintenance	0	3,626	0	0	1,514	0	0	0	0	0	0	5,140	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	10,891	0	0	1,514	0	0	0	0	0	0	12,405	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	197	0	0	0	0	0	0	0	0	0	197	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,311)	0	0	0	0	0	0	0	0	0	0	(4,311)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,311)	197	0	0	0	0	0	0	0	0	0	(4,114)	16
	C. General Administration													
17	Administrative	0	(224,650)	0	0	0	0	0	0	0	0	0	(224,650)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,912	0	20,253	5,910	0	0	0	0	0	0	43,075	19
20	Fees, Subscriptions & Promotions	(400)	0	707	0	0	0	0	0	0	0	0	307	20
21	Clerical & General Office Expenses	(920)	0	77,421	0	0	0	0	0	0	0	0	76,501	21
22	Employee Benefits & Payroll Taxes	0	0	43,290	922	0	0	0	0	0	0	0	44,212	22
23	Inservice Training & Education	0	0	148	0	0	0	0	0	0	0	0	148	23
24	Travel and Seminar	0	0	72	0	0	0	0	0	0	0	0	72	24
25	Other Admin. Staff Transportation	0	0	6,091	0	0	0	0	0	0	0	0	6,091	25
26	Insurance-Prop.Liab.Malpractice	0	0	858	0	42,409	0	0	0	0	0	0	43,267	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,320)	(207,738)	128,587	21,175	48,319	0	0	0	0	0	0	(10,977)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,631)	(196,650)	128,587	21,175	49,833	0	0	0	0	0	0	(2,686)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,246)	0	17,132	1,405	60,468	0	0	0	0	0	0	57,759	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	4,339	0	0	0	0	0	0	4,339	31
32	Interest	0	0	503	50,132	65,728	0	0	0	0	0	0	116,363	32
33	Real Estate Taxes	0	0	394	0	21,332	0	0	0	0	0	0	21,726	33
34	Rent-Facility & Grounds	0	0	0	0	(292,291)	0	0	0	0	0	0	(292,291)	34
35	Rent-Equipment & Vehicles	0	0	1,393	0	0	0	0	0	0	0	0	1,393	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,246)	0	19,422	51,537	(140,424)	0	0	0	0	0	0	(90,711)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(103,459)	0	0	0	0	0	0	0	0	0	0	(103,459)	43
44	**TOTAL Special Cost Centers**	(103,459)	0	0	0	0	0	0	0	0	0	0	(103,459)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(130,336)	(196,650)	148,009	72,712	(90,591)	0	0	0	0	0	0	(196,856)	45

VII. RELATED PARTIES

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

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. [X] 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 Management, Inc.	100.00%	$ 6,641	$ 6,641	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	121	121	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	116	116	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	387	387	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,626	3,626	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%	197	197	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	286,400	Petersen Health Care Management, Inc.	100.00%	61,750	(224,650)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	16,912	16,912	12
13	V								13
14	Total			$ 286,400			$ 89,750	$ * (196,650)	14

* 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: 1/1/2016 Ending: 12/31/2016

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. [X] 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%	$ 707	$ 707	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	77,421	77,421	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	43,290	43,290	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	148	148	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	72	72	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	6,091	6,091	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	858	858	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	17,132	17,132	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	503	503	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	394	394	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,393	1,393	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			$			$ 148,009	$ * 148,009	39

* 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: 1/1/2016 Ending: 12/31/2016

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. [X] 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)	
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%	20,253	20,253	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	0		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%	922	922	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%	1,405	1,405	33
34	V	31	Amortization		Petersen Management Company, LLC	100.00%	0		34
35	V	32	Interest		Petersen Management Company, LLC	100.00%	50,132	50,132	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			$			$ 72,712	$ * 72,712	39

* 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: 1/1/2016 Ending: 12/31/2016

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. [X] 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	$	Petersen 28, LLC	100.00%	$ 1,514	$ 1,514	15
16	V	19	Professional Services	$	Petersen 28, LLC	100.00%	5,910	5,910	16
17	V	26	Insurance-Property		Petersen 28, LLC	100.00%	29,633	29,633	17
18	V	26	Insurance-MIP		Petersen 28, LLC	100.00%	12,776	12,776	18
19	V	30	Depreciation		Petersen 28, LLC	100.00%	60,468	60,468	19
20	V	31	Amortization		Petersen 28, LLC	100.00%	4,339	4,339	20
21	V	32	Interest	715	Petersen 28, LLC	100.00%	66,443	65,728	21
22	V	33	Real Estate Taxes		Petersen 28, LLC	100.00%	21,332	21,332	22
23	V	34	Rent-Income and Grounds	292,291	Petersen 28, LLC	100.00%		(292,291)	23
24	V								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			$ 293,006			$ 202,415	$ * (90,591)	39

* 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: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	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 Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 1/1/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	1,521,544	75	$ 312,540	$ 357,910	32,331	$ 6,641	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	32,331	121	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	32,331	116	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	32,331	387	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	32,331	3,626	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	32,331	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	32,331	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	32,331	197	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	32,331	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	32,331	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	32,331	61,750	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	32,331	16,912	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	32,331	707	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	32,331	77,421	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	32,331	43,290	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	32,331	148	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	32,331	72	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	32,331	6,091	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	32,331	858	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	32,331	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	32,331	17,132	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	32,331	503	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	32,331	394	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	32,331	1,393	24
25	TOTALS					$ 13,182,740	$ 11,510,481		$ 237,759	25

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	170,636	6	$	$	32,331	$	1
2	2	Food	Resident Days	170,636	6			32,331		2
3	3	Housekeeping	Resident Days	170,636	6			32,331		3
4	4	Laundry	Resident Days	170,636	6			32,331		4
5	5	Utilities	Resident Days	170,636	6			32,331		5
6	6	Maintenance	Resident Days	170,636	6			32,331		6
7	7	Mgmt. Allocation of Benefits	Resident Days	170,636	6			32,331		7
8	10	Nursing and Medical Records	Resident Days	170,636	6			32,331		8
9	15	Mgmt. Allocation of Benefits	Resident Days	170,636	6			32,331		9
10	17	Administrative	Resident Days	170,636	6			32,331		10
11	19	Professional Services	Resident Days	170,636	6	106,890		32,331	20,253	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	170,636	6			32,331		12
13	21	Clerical and General Office	Resident Days	170,636	6			32,331		13
14	22	Employee Benefits & Payroll	Resident Days	170,636	6	4,868		32,331	922	14
15	23	Inservice Training & Education	Resident Days	170,636	6			32,331		15
16	24	Travel and Seminar	Resident Days	170,636	6			32,331		16
17	25	Other Admin. Staff Transport.	Resident Days	170,636	6			32,331		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	170,636	6			32,331		18
19	30	Depreciation	Resident Days	170,636	6	7,413		32,331	1,405	19
20	31	Amortization	Resident Days	170,636	6			32,331		20
21	32	Interest	Resident Days	170,636	6	264,585		32,331	50,132	21
22	33	Real Estate Taxes	Resident Days	170,636	6			32,331		22
23	34	Rent-Facility and Grounds	Resident Days	170,636	6			32,331		23
24	35	Rent-Equipment & Vehicles	Resident Days	170,636	6			32,331		24
25	TOTALS					$ 383,756	$		$ 72,712	25

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	1st Merit		X	HUD Mortgage	Varies	5/1/13	2,146,000	$ 1,937,808	4/30/38	Varies	$ 66,443	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,146,000	$ 1,937,808			$ 66,443	9
	B. Non-Facility Related*											
10								Interest Income Offset			(715)	10
11								Home Office Allocation-PMC			50,132	11
12								Home Office Allocation-PHCM			503	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 49,920	14
15	TOTALS (line 9+line14)						$ 2,146,000	$ 1,937,808			$ 116,363	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.)

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 2015 report.	$	21,360	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.)	$	21,032	2
3. Under or (over) accrual (line 2 minus line 1).	$	(328)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	21,660	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** **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	394	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	21,726	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2011	20,009	8
	2012	20,530	9
	2013	21,224	10
	2014	20,739	11
	2015	21,032	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 MIKE KOCHER

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

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

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

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	06-36-126-015	Long-Term Care Facility	$ 21,031.54	$ 21,031.54
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,031.54	$ 21,031.54

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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? [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? [ ] YES [X] 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: 4,339
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	120,000	2005	$ 60,000	1
2					2
3	TOTALS	120,000		$ 60,000	3

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 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	106		2005	1970	$ 1,190,500	$	25	$ 24,142	$ 24,142	$ 265,230	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2006	15,000		15	1,000	1,000	11,249	9
10	Durolast			2006	26,843		20	1,342	1,342	14,091	10
11	Sign front door			2006	3,118		20	156	156	1,638	11
12	Fire Alarm			2007	2,222		15	148	148	1,406	12
13	Roof Top Air Conditioner			2007	4,990		15	333	333	3,163	13
14	Sprinkler System			2008	86,980		39	2,230	2,230	18,955	14
15	Furnace			2008	6,600		5			6,600	15
16	Sewer Line Repair			2009	10,514		7	751	751	10,514	16
17	Sidewalks			2009	8,930		15	596	596	4,470	17
18	Nurses Station			2010	2,865		5			2,865	18
19	Backflow Preventer			2011	3,669		10	366	366	1,657	19
20	Water Heater			2011	3,745		10	374	374	2,057	20
21	Water Heater			2012	3,856		7	550	550	2,475	21
22	Roof Replacement			2014	97,480		25	3,900	3,900	9,750	22
23	Air conditioner			2014	7,305		15	487	487	1,218	23
24	Tile Flooring for Kitchen, Hallways, Dining Room			2016	26,700		15	890	890	890	24
25	Water Heater			2016	3,431		7	245	245	245	25
26	Parking Lot Paving, Sidewalk and Dumpster Pad Replacement			2016	47,547		15	1,585	1,585	1,585	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					13,324			(13,324)		32
33											33
34	2016-Home Office Allocation-Building Improvements				14,274			343	343		34
35	2016-Home Office Allocation-Land Improvements				1,313			85	85		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: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,567,882	$ 62,539		$ 39,523	$ (23,016)	$ 360,058	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: 1/1/2016 Ending: 12/31/2016

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	$ 65,225	$ 4,424	$ 6,522	$ 2,098	5-10 yrs.	$ 34,253	71
72	Current Year Purchases	16,036	1,046	1,146	100	7 yrs.	1,146	72
73	Fully Depreciated Assets	216,236					216,236	73
74	Home Office Allocation			18,109	18,109			74
75	TOTALS	$ 297,497	$ 5,470	$ 25,777	$ 20,307		$ 251,635	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)	$ 1,925,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,009	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,300	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,709)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 611,693	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			93
94	N/A		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: 1/1/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 24,459 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 **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 12,333
Dishwasher	709
Copier	10,024
Home Office Allocation	1,393
	24,459

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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	
		Schedule V	Staff		Outside Practitioner (other than consultant)		Supplies			
	Service	Line & Column Reference	Units of Service	Cost	Units	Cost	(Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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				14		14	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			$		$	$ 14		$ 14	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 # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 817,276	$ 817,276	1
2	Cash-Patient Deposits	4,512	4,512	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 24,894)	1,160,929	1,160,929	3
4	Supply Inventory (priced at Cost)	12,636	12,636	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,464	36,446	6
7	Other Prepaid Expenses	100,924	100,924	7
8	Accounts Receivable (owners or related parties)		24,403	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,124,741	$ 2,157,126	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		1,204,774	14
15	Leasehold Improvements, at Historical Cost	54,852	363,108	15
16	Equipment, at Historical Cost	47,002	297,497	16
17	Accumulated Depreciation (book methods)	(15,173)	(611,693)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		108,486	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(15,911)	20
21	Restricted Funds		765,191	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 86,681	$ 2,171,452	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,211,422	$ 4,328,578	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 237,757	$ 301,823	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,370	116,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,719	60,719	31
32	Accrued Real Estate Taxes(Sch.IX-B)		21,660	32
33	Accrued Interest Payable		5,458	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	3,313	3,313	36
37	Accrued Management Fees	13,371	13,371	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 431,530	$ 522,714	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,937,808	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,151,361	592,252	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,151,361	$ 2,530,060	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,582,891	$ 3,052,774	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 628,531	$ 1,275,804	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,211,422	$ 4,328,578	48

*(See instructions.)

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 226,844	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	(2,029)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 224,815	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	403,716	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)**	$ 403,716	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)**	$ 628,531	24 *

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,132,966	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,132,966	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		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)**	$	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	4,311	28
28a	Miscellaneous Revenue	920	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,231	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,138,197	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	750,497	31
32	Health Care	1,705,434	32
33	General Administration	589,945	33
	B. Capital Expense		
34	Ownership	331,155	34
	C. Ancillary Expense		
35	Special Cost Centers	103,473	35
36	Provider Participation Fee	253,977	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,734,481	40
41	**Income before Income Taxes (line 30 minus line 40)****	403,716	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 403,716	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,326,684	44
45	Private Pay - Net Inpatient Revenue	806,282	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)	$ 4,132,966	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: 1/1/2016 Ending: 12/31/2016

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	1,797	1,917	$ 65,058	$ 33.94	1
2	Assistant Director of Nursing	1,917	1,949	45,135	23.16	2
3	Registered Nurses	9,956	10,264	231,064	22.51	3
4	Licensed Practical Nurses	17,380	17,832	299,769	16.81	4
5	CNAs & Orderlies	62,859	64,550	771,841	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	2,071	26,319	12.71	9
10	Activity Assistants	1,919	2,084	22,223	10.66	10
11	Social Service Workers	1,741	1,741	25,817	14.83	11
12	Dietician					12
13	Food Service Supervisor	2,052	2,052	32,904	16.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,972	13,136	111,115	8.46	15
16	Dishwashers					16
17	Maintenance Workers	4,160	4,160	52,308	12.57	17
18	Housekeepers	18,073	18,995	174,567	9.19	18
19	Laundry	2,544	2,567	21,866	8.52	19
20	Administrator	2,080	2,080	61,750	29.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,826	2,007	30,573	15.23	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	885	885	19,296	21.80	31
32	Other Health C: Alzheimer's Coord	1,917	1,949	46,050	23.63	32
33	Other(specify) CPC	1,980	2,012	52,211	25.95	33
34	TOTAL (lines 1 - 33)	147,967	152,251	$ 2,089,866 *	$ 13.73	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	29	$ 1,757	L1, C3	35
36	Medical Director	Monthly	11,250	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,069	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)	29	$ 20,076		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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Jeremy Biggerstaff	Administrator	0	$	26,750
Patricia Friar	Administrator	0		35,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	61,750

B. Administrative - Other

Description		Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$	286,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	286,400

C. Professional Services

Vendor/Payee	Type		Amount
Charter Communications	Computer Services	$	840
Honkamp, Kruger, & Co.	Accounting Services		2,272
E-Health Data Solutions	Computer Services		3,051
Capital Finance Group	Refund of Refinancing Fees		(5,910)
Mt. Vernon Petty Cash	Legal Fees		180
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	433

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	36,288
Unemployment Compensation Insurance		41,763
FICA Taxes		152,876
Employee Health Insurance		7,092
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Relations		6,300
Employee Retirement		440
Home Office Allocation		44,212
TOTAL (agree to Schedule V, line 22, col.8)	$	288,971

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #		Amount
N/A			
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	
Advertising: Employee Recruitment		433
Health Care Worker Background Check (Indicate # of checks performed 36)		549
Patient Background Checks 39		595
Miscellaneous Licenses & Permits		519
Miscellaneous Dues & Subscriptions		2,400
Home Office Allocation		707
Less: Public Relations Expense		(400)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)	$	4,803

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		162
Home Office Allocation		72
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	234

**See instructions.

Mt Vernon Health Care Center
0052290
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		433
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	75
Miscellaneous	Legal	25
Miller Hall and Triggs	Legal	131
Healthcare Resources International	Legal	652
Hunziker Law	Legal	156
Lexis Nexis	Legal	13
First Merit Bank	Legal	250
CliftonLarson Allen	Accountants	2,004
Ginoli & Co.	Accountants	10,151
First Merit Bank	Accountants	5,660
Miscellaneous	Computer Services	86
Change Healthcare	Computer Services	13
PTC Select	Computer Services	8
Advanced Answers on Demand	Computer Services	5,954
Stratus Networks	Computer Services	606
Kemper Technology	Computer Services	399
AT&T	Computer Services	9
Ability Network	Computer Services	2,538
CIAN	Computer Services	303
Comcast	Computer Services	49
CCH	Computer Services	20
Charter Communications	Computer Services	59
Allscripts	Computer Services	885
ATS	Computer Services	399
Allpayer Exchange	Computer Services	20
Optimizer	Other Prof Fees	61
Ankura	Other Prof Fees	462
David Budde	Other Prof Fees	53
Bruner, Cooper, Zuck	Other Prof Fees	135
Marotta, Gund, Budd, Dzerda	Other Prof Fees	11,821
Professional Software and Services	Other Prof Fees	33
Hughes Valuation Services	Other Prof Fees	42
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		43,508

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $2000**

(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. $ **35,821** 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. $ **253,977**
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. $ **No**

(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. $ **4,311**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

RECONCILIATI **Mt Vernon Health Care** **11:19 AM** **7/7/2017**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Deta	-196,856	equal to	-196,856	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expens	116,363	equal to	116,363	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	21,726	equal to	21,726	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization ex	4,339	equal to	4,339	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	65,300	equal to	65,300	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	32,716	equal to	32,716	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service		equal to	0	#VALUE!	#VALUE!	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- S	14	equal to	14	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	750,497	equal to	750,497	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,705,434	equal to	1,705,434	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	589,945	equal to	589,945	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	331,155	equal to	331,155	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	103,473	equal to	103,473	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Pr	253,977	equal to	253,977	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,530,424	equal to	1,530,424	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aid	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	48,542	equal to	48,542	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Ser	25,817	equal to	25,817	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	144,019	equal to	144,019	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	52,308	equal to	52,308	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	174,567	equal to	174,567	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	21,866	equal to	21,866	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administra	61,750	equal to	61,750	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	30,573	equal to	30,573	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	2,089,866	equal to	2,028,116	61,750	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consulta	1,757	< or = to	1,757	0	FAILED	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	11,250	< or = to	11,250	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	7,069	< or = to	7,189	-120	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consulta	0	< or = to	457	-457	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	61,750	equal to	61,750	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	286,400	equal to	286,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	433	equal to	433	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	288,971	equal to	288,971	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	4,803	equal to	4,803	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	234	equal to	234	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	253,977	equal to	253,977	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medica	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-66,520	equal to	-66,520	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balan	1,937,808	equal to	1,937,808	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax	21,660	equal to	21,660	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	60,000	equal to	60,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,567,882	equal to	1,567,882	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and	297,497	equal to	297,497	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	611,693	equal to	611,693	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	628,531	equal to	628,531	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	403,716	equal to	403,716	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,211,422	equal to	2,211,422	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 7/7/2017 11:19:46 AM

HSA Number: 4 Name: **Mt Vernon Health Care Center**

Cost report peri From: 1/1/2016 To: 12/31/2016 Base Number: 492

If this is an ICF/DD 16 facility, e N

Licensed bed d 38,690 Occupancy: 32,331 Pct. of occupan 83.56%

ıblic Aid Support Rate: $ ______

Genl Services S	392,760	Col 1, Line 8 ---Audit Adj:	______
Genl Admin Sal	30,573	Col 1, Line 28 ---Audit Adj:	______
Total Salary Wa	2,028,116	Col 1, Line 44 ---Audit Adj:	______
Employee Bene	288,971	Col 8, Line 22 ---Audit Adj:	______
Total General S	762,902	Col 8, Line 8 ---Audit Adj:	______
Total General A	579,763	Col 8, Line 28 ---Audit Adj:	______

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)	$392,760
Divided by Total Wages (Column 1, Line 44)	$2,028,116
General service wages as percent of total wages	19.3658%
Employee Benefits (Column 10, Line 22)	$288,971
Allocation of Employee Benefits to General Services Costs	$55,962
Plus Total General Services (Column 10, Line 8)	$762,902
New Total General Services Cost	$818,864

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).	$30,573
Divided by Total Wages (Column 1, Line 45)	$2,028,116
General administration wages as a percent of total wages	1.5075%
Employee Benefits (Column 10, Line 22)	$288,971
Allocation of Employee Benefits to General Admin. Costs	$4,356
Plus Total General Administration (Column 10, Line 28)	$579,763
Minus Total Fringe (Column 10, Line 22)	$288,971
New Total General Administration Cost	$295,148

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation factors are used for the General Services and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month =	[illegible] divided by 2 =	[illegible]
Beginning Day + Ending Day =	[illegible] divided by 30.4 =	[illegible]
Beginning Year + Ending Year =	[illegible] multiplied by 6 =	[illegible]
Sum of the three lines		[illegible]
Subtract from the sum		[illegible]
Base Number (calculated to a whole number, fraction dropped)		492

B. Select the Appropriate Inflation Multipliers

Refer to Table I, Inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplier	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I A) by the appropriate multiplier from Table I.

New Total General Services Cost (Step I A)	$818,864	
General Services Multiplier (Step II B)	1	
Updated General Services Cost		$818,864

2 Multiply New Total General Administration Cost (from Step I B) by the appropriate multiplier from Table I.

New Total General Services Cost (Step IB)	$295,148	
General Administration Multiplier (Step II B)	1	
Updated General Services Cost		$295,148
3 Total Updated Support Costs 1 + 2		$1,114,012

STEP III Convert Total Updated Support Costs (C 3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $33.21

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$1,114,012
Total Patient Days (Cost Report)	32,331
Support Costs per Diem	$34.46

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	38,690
Multiplied by	0.93
	35,982
Minus total Patient Days	32,331
	3,651
One-third of difference	1,217
Plus Total Patient Days	32,331
Adjusted Occupancy	33,548
Total Support Costs (Step II, C, 3, above)	$1,114,012
Divided by Adjusted Occupany	33548
Support Costs Per Diem	$33.21

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$33.21
Difference	$14.23
Multiply the Difference by	0.5
One-Half of the Difference	$7.12
Plus Support Costs Per Diem	$33.21
Support Rate if costs are between 35th and 75th percentile	40.33

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$33.21
Difference	$14.23
Multiply the Difference by	0.5
One-Half of the Difference	$7.12
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$3.795
Plus Support Costs Per Diem	$33.21
Support Rate if support costs less than 35th percentile	$37.01

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$37.01**

75th Percentile is	$47.44
35th Percentile is	$39.95

Table I

Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II

SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)

SupportRate percentiles by HSA

Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	144,019	16,135	1,757	161,911	0	161,911	6,641	168,552
2. Food Purchase	0	208,305	0	208,305	0	208,305	121	208,426
3. Housekeeping	174,567	31,490	0	206,057	0	206,057	116	206,173
4. Laundry	21,866	8,058	0	29,924	0	29,924	0	29,924
5. Heat and Other Utilities	0	0	67,489	67,489	0	67,489	387	67,876
6. Maintenance	52,308	9,193	15,310	76,811	0	76,811	5,140	81,951
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	392,760	273,181	84,556	750,497	0	750,497	12,405	762,902
9. Medical Director	0	0	11,250	11,250	0	11,250	0	11,250
10. Nursing & Medical Records	1,530,424	81,742	7,189	1,619,355	0	1,619,355	-598	#######
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	48,542	13	457	49,012	0	49,012	-4,311	44,701
12. Social Services	25,817	0	0	25,817	0	25,817	0	25,817
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,604,783	81,755	18,896	1,705,434	0	1,705,434	-4,909	#######
17. Administrative	0	0	286,400	286,400	0	286,400	-224,650	61,750
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	433	433	0	433	43,075	43,508
20. Fees, Subscriptions & Promotion	0	0	4,496	4,496	0	4,496	307	4,803
21. Clerical & General Office	30,573	3,136	11,018	44,727	0	44,727	77,296	122,023
22. Employee Benefits & Payroll	0	0	244,759	244,759	0	244,759	44,212	288,971
23. Inservice Training & Education	0	0	0	0	0	0	148	148
24. Travel and Seminar	0	0	162	162	0	162	72	234
25. Other Admin. Staff Trans	0	0	5,991	5,991	0	5,991	6,091	12,082
26. Insurance-Prop.Liab.Malpractice	0	0	2,977	2,977	0	2,977	43,267	46,244
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	30,573	3,136	556,236	589,945	0	589,945	-10,182	579,763
29. Total General Administrative	2,028,116	358,072	659,688	3,045,876	0	3,045,876	-2,686	#######
30. Depreciation	0	0	7,541	7,541	0	7,541	57,759	65,300
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	4,339	4,339
32. Interest	0	0	0	0	0	0	116,363	116,363
33. Real Estate	0	0	0	0	0	0	21,726	21,726
34. Rent - Facility & Grounds	0	0	292,291	292,291	0	292,291	-292,291	0
35. Rent - Equipment & Vehicles	0	0	31,323	31,323	0	31,323	1,393	32,716
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	331,155	331,155	0	331,155	-90,711	240,444
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	14	0	14	0	14	0	14
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	253,977	253,977	0	253,977	0	253,977
43. Other (specify):*	0	281	103,178	103,459	0	103,459	-103,459	0
44. Total Special Cost Ce	0	295	357,155	357,450	0	357,450	-103,459	253,991
45. Grand Total	2,028,116	358,367	1,347,998	3,734,481	0	3,734,481	-196,856	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	817,276	817,276
2. Cash - Patient Deposits	4,512	4,512
3. Accounts & Notes Recievable	1,160,929	1,160,929
4. Supply Inventory	12,636	12,636
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,464	36,446
7. Other Prepaid Expenses	100,924	100,924
8. Accounts Receivable-Owner/Related Party	0	24,403
9. Other (specify):	0	0
10. Total current assets	2,124,741	2,157,126
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	60,000
14. Buildings, at Historical Cost	0	1,204,774
15. Leasehold Improvements, Historical Cost	54,852	363,108
16. Equipment, at Historical Cost	47,002	297,497
17. Accumulated Depreciation (book methods)	-15,173	-611,693
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	108,486
20. Accum Amort - Org/Pre-Op Costs	0	-15,911
21. Restricted Funds	0	765,191
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	86,681	2,171,452
25. Total Assets	2,211,422	4,328,578
CURRENT LIABILITIES		
26. Accounts Payable	237,757	301,823
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	116,370	116,370
31. Accrued Taxes Payable	60,719	60,719
32. Accrued Real Estate Taxes	0	21,660
33. Accrued Interest Payable	0	5,458
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	3,313	3,313
37. Other Current Liabilities (specify):	13,371	13,371
38. Total Current Liabilities	431,530	522,714
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	1,937,808
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,151,361	592,252
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,151,361	2,530,060
46.Total Liabilities	1,582,891	3,052,774
47.Total Equity	628,531	1,275,804
48.Total Liabilities and Equity	2,211,422	4,328,578

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,132,966
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	4,132,966
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	4,311
28. Other Revenue (specify):	920
Subtotal - Other Revenue	5,231
30. Total Revenue	4,138,197
31. General Services	732,491
32. Health Care	1,484,659
33. General Administration	567,499
34. Ownership	309,724
35. Special Cost Centers	36,403
35. Provider Participation Fee	245,301
37. Other	0
40. Total Expenses	3,376,077
41. Income Before Income Taxes	762,120
42. Income Taxes	0
43. Net Income or Loss for the Year	762,120