FOR BHF USE

LL1

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.

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

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
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,690	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	19,784	3,894		23,678	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,784	3,894		23,678	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.20%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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 3/1/206 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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	153,756	22,941		176,697		176,697	6,305	183,002			1
2	Food Purchase		167,999		167,999		167,999	(4,155)	163,844			2
3	Housekeeping	193,092	32,520		225,612		225,612	122	225,734			3
4	Laundry	11,223	9,732		20,955		20,955		20,955			4
5	Heat and Other Utilities			57,964	57,964		57,964	430	58,394			5
6	Maintenance	28,169	10,734	21,108	60,011		60,011	3,786	63,797			6
7	Other (specify):*											7
8	**TOTAL General Services**	386,240	243,926	79,072	709,238		709,238	6,488	715,726			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,334,664	77,978	118,384	1,531,026		1,531,026	9,248	1,540,274			10
10a	Therapy											10a
11	Activities	56,185	166		56,351		56,351	(230)	56,121			11
12	Social Services	28,192			28,192		28,192		28,192			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,419,041	78,144	130,384	1,627,569		1,627,569	9,018	1,636,587			16
	C. General Administration											
17	Administrative	66,504		178,300	244,804		244,804	(143,237)	101,567			17
18	Directors Fees											18
19	Professional Services			4,842	4,842		4,842	58,785	63,627			19
20	Dues, Fees, Subscriptions & Promotions			2,887	2,887		2,887	2,798	5,685			20
21	Clerical & General Office Expenses	27,592	705	15,926	44,223		44,223	39,270	83,493			21
22	Employee Benefits & Payroll Taxes			219,604	219,604		219,604	10,731	230,335			22
23	Inservice Training & Education							65	65			23
24	Travel and Seminar							20	20			24
25	Other Admin. Staff Transportation			2,291	2,291		2,291	4,517	6,808			25
26	Insurance-Prop.Liab.Malpractice			2,584	2,584		2,584	52,477	55,061			26
27	Other (specify):*											27
28	**TOTAL General Administration**	94,096	705	426,434	521,235		521,235	25,426	546,661			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,899,377	322,775	635,890	2,858,042		2,858,042	40,932	2,898,974			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: 1/1/2020 Ending: 12/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,370	8,370		8,370	51,237	59,607			30
31	Amortization of Pre-Op. & Org.							4,339	4,339			31
32	Interest							52,784	52,784			32
33	Real Estate Taxes							23,002	23,002			33
34	Rent-Facility & Grounds			195,350	195,350		195,350	(195,350)				34
35	Rent-Equipment & Vehicles			17,611	17,611		17,611	123,715	141,326			35
36	Other (specify):*											36
37	**TOTAL Ownership**			221,331	221,331		221,331	59,727	281,058			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,592	201,592		201,592		201,592			42
43	Other (specify):*		80	65,614	65,694		65,694	(65,694)				43
44	**TOTAL Special Cost Centers**		80	267,206	267,286		267,286	(65,694)	201,592			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,899,377	322,855	1,124,427	3,346,659		3,346,659	34,965	3,381,624			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: 1/1/2020 Ending: 12/31/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,155)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,120)	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	(21,634)	30		9
10	Interest and Other Investment Income	(292)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(334)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(41,197)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,023)	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	(4,842)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (92,597)		$	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)	127,562	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 127,562		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 34,965		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: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	(111)	21	1
2	Offset Transportation Revenue	(230)	11	2
3	Disallowed Chamber of Commerce Dues	(430)	20	3
4	Disallowed Special Events	(100)	43	4
5	Labs-Part A	(3,920)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(51)	10	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
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26				26
27				27
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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**	(4,842)		49

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	$ 6,305	$ 6,305	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	122	122	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	430	430	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,786	3,786	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%	5,908	5,908	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	178,300	Petersen Health Care Management, Inc.	100.00%	35,063	(143,237)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	20,711	20,711	12
13	V								13
14	Total			$ 178,300			$ 72,325	$ * (105,975)	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: 1/1/2020 Ending: 12/31/2020

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	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 3,228	$ 3,228	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,092	39,092	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,731	10,731	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	65	65	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	20	20	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,517	4,517	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	688	688	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	6,382	6,382	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	311	311	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	248	248	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,289	2,289	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			$			$ 67,571	$ * 67,571	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: 1/1/2020 Ending: 12/31/2020

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 Health Care Management, Inc.	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care Management, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,391	3,391	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	31,374	31,374	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Care Management, Inc.	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	0		32
33	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	2,364	2,364	33
34	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	370	370	35
36	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care Management, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	121,426	121,426	38
39	Total			$			$ 158,925	$ * 158,925	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: 1/1/2020 Ending: 12/31/2020

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	19	Professional Services	$	Petersen 28, LLC	100.00%	$ 6,700	$ 6,700	15
16	V	21	Equipment		Petersen 28, LLC	100.00%	289	289	16
17	V	26	Insurance-Liability		Petersen 28, LLC	100.00%	31,816	31,816	17
18	V	26	Insurance-Property		Petersen 28, LLC	100.00%	8,888	8,888	18
19	V	26	Insurance-Mortgage Insurance		Petersen 28, LLC	100.00%	11,085	11,085	19
20	V	30	Depreciation		Petersen 28, LLC	100.00%	64,125	64,125	20
21	V	31	Amortization		Petersen 28, LLC	100.00%	4,339	4,339	21
22	V	32	Interest	1,367	Petersen 28, LLC	100.00%	53,762	52,395	22
23	V	33	Real Estate Taxes		Petersen 28, LLC	100.00%	22,754	22,754	23
24	V	34	Rent-Income and Grounds	195,350	Petersen 28, LLC	100.00%		(195,350)	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			$ 196,717			$ 203,758	$ * 7,041	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: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health 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 Quali	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: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	1,282,791	75	$ 341,562	$ 398,718	23,678	$ 6,305	1
2	2	Food	Resident Days	1,282,791	75	0	0	23,678	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	23,678	122	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	23,678	430	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	23,678	3,786	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	23,678	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	23,678	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	23,678	5,908	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	23,678	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	23,678	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	23,678	35,063	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	23,678	20,711	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	23,678	3,228	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	23,678	39,092	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	23,678	10,731	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	23,678	65	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	23,678	20	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	23,678	4,517	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	23,678	688	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	23,678	6,382	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	23,678	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	23,678	311	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	23,678	248	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	23,678	2,289	24
25	TOTALS					$ 7,579,077	$ 11,195,006		$ 139,896	25

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	130,685	6	$	$	23,678	$	1
2	2	Food	Resident Days	130,685	6			23,678		2
3	3	Housekeeping	Resident Days	130,685	6			23,678		3
4	4	Laundry	Resident Days	130,685	6			23,678		4
5	5	Utilities	Resident Days	130,685	6			23,678		5
6	6	Maintenance	Resident Days	130,685	6			23,678		6
7	7	Mgmt. Allocation of Benefits	Resident Days	130,685	6			23,678		7
8	10	Nursing and Medical Records	Resident Days	130,685	6	18,718		23,678	3,391	8
9	15	Mgmt. Allocation of Benefits	Resident Days	130,685	6			23,678		9
10	17	Administrative	Resident Days	130,685	6			23,678		10
11	19	Professional Services	Resident Days	130,685	6	173,161		23,678	31,374	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	130,685	6			23,678		12
13	21	Clerical and General Office	Resident Days	130,685	6			23,678		13
14	22	Employee Benefits & Payroll	Resident Days	130,685	6			23,678		14
15	23	Inservice Training & Education	Resident Days	130,685	6			23,678		15
16	24	Travel and Seminar	Resident Days	130,685	6			23,678		16
17	25	Other Admin. Staff Transport.	Resident Days	130,685	6			23,678		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	130,685	6			23,678		18
19	30	Depreciation	Resident Days	130,685	6	13,046		23,678	2,364	19
20	31	Amortization	Resident Days	130,685	6			23,678		20
21	32	Interest	Resident Days	130,685	6	2,043		23,678	370	21
22	33	Real Estate Taxes	Resident Days	130,685	6			23,678		22
23	34	Rent-Facility and Grounds	Resident Days	130,685	6			23,678		23
24	35	Rent-Equipment & Vehicles	Resident Days	130,685	6	670,184		23,678	121,426	24
25	TOTALS					$ 877,152	$		$ 158,925	25

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Huntington Bank		X	HUD Mortgage	Varies	5/1/13	2,146,000	$ 1,673,638	4/30/38	Varies	$ 53,762	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,146,000	$ 1,673,638			$ 53,762	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,659)	10
11								Home Office Allocation-PHCM			311	11
12								Home Office Allocation-PMC			370	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (978)	14
15	TOTALS (line 9+line14)						$ 2,146,000	$ 1,673,638			$ 52,784	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,085 Line # 26

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

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 23,052	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.)		$ 22,562	2
3. Under or (over) accrual (line 2 minus line 1).		$ (490)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,244	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Home Office Allocation** 248	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 23,002	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	21,032	8
	2016	21,469	9
	2017	21,946	10
	2018	22,375	11
	2019	22,562	12

Accrual based on prior year tax bill.

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-36-126-015	Long-Term Care Facility	$ 22,561.86	$ 22,561.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,561.86	$ 22,561.86

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 108,486
2. Number of Years Over Which it is Being Amortized: 25
3. Current Period Amortization: 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: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		2005	1970	$ 1,190,500	$	25	$ 24,142	$ 24,142	$ 361,798	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2006	15,000		15	751	751	15,000	9
10	Durolast			2006	26,843		20	1,342	1,342	19,459	10
11	Sign front door			2006	3,118		20	156	156	2,262	11
12	Fire Alarm			2007	2,222		15	148	148	1,998	12
13	Roof Top Air Conditioner			2007	4,990		15	333	333	4,495	13
14	Sprinkler System			2008	86,980		39	2,230	2,230	27,875	14
15	Furnace			2008	6,600		5			6,600	15
16	Sewer Line Repair			2009	10,514		7			10,514	16
17	Sidewalks			2009	8,930		15	596	596	6,854	17
18	Nurses Station			2010	2,865		5			2,865	18
19	Backflow Preventer			2011	3,669		10	366	366	3,121	19
20	Water Heater			2011	3,745		10	374	374	3,553	20
21	Water Heater			2012	3,856		7			3,856	21
22	Roof Replacement			2014	97,480		25	3,900	3,900	25,350	22
23	Air conditioner			2014	7,305		15	487	487	3,166	23
24	Tile Flooring for Kitchen, Hallways, Dining Room			2016	26,700		15	1,780	1,780	8,010	24
25	Water Heater			2016	3,431		7	490	490	2,205	25
26	Parking Lot Paving, Sidewalk and Dumpster Pad Replacement			2016	47,547		15	3,170	3,170	14,265	26
27	Door Alarm System			2020	6,275		7	448	448	448	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					12,972			(12,972)		32
33											33
34	2020-Home Office Allocation-Building Improvements				11,972			287	287		34
35	2020-Home Office Allocation-Land Improvements				1,201			76	76		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: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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
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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)		$ 1,571,743	$ 62,187		$ 41,076	$ (21,111)	$ 523,694	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: 1/1/2020 Ending: 12/31/2020

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	$ 83,413	$ 10,308	$ 10,148	$ (160)	5-10 yrs.	$ 47,213	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	240,222					240,222	73
74	Home Office Allocation			8,383	8,383			74
75	TOTALS	$ 323,635	$ 10,308	$ 18,531	$ 8,223		$ 287,435	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)	$ 1,955,378	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,495	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 59,607	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,888)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 811,129	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			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: 1/1/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 141,326 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Mt Vernon Health Care Center
0052290
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 5,686
Dishwasher	701
Copier	11,224
Home Office Allocation	123,715
	141,326

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 842,009	$ 842,009	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 84,272)	1,754,330	1,754,330	3
4	Supply Inventory (priced at Cost)	12,636	12,636	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,257	32,442	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		22,638	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,628,232	$ 2,664,055	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		1,202,472	14
15	Leasehold Improvements, at Historical Cost	57,769	369,271	15
16	Equipment, at Historical Cost	40,573	323,635	16
17	Accumulated Depreciation (book methods)	(51,477)	(811,129)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		108,486	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(33,269)	20
21	Restricted Funds		943,642	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	1,716,019	1,732,703	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,762,884	$ 3,895,811	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,391,116	$ 6,559,866	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 423,982	$ 425,682	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,292	91,292	30
31	Accrued Taxes Payable (excluding real estate taxes)	101,973	101,973	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,244	32
33	Accrued Interest Payable		4,714	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	1,067	1,067	36
37	Accrued Management Fees			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 618,314	$ 647,972	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,673,638	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	500,000	500,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 500,000	$ 2,173,638	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,118,314	$ 2,821,610	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,272,802	$ 3,738,256	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,391,116	$ 6,559,866	48

***(See instructions.)**

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 103,746	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	815,633	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 919,379	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,353,423	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)**	$ 2,353,423	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)**	$ 3,272,802	24 *

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

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,314,054	1
2	Discounts and Allowances for all Levels	(749,140)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,564,914	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	4,155	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	40	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,195	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	292	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 292	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	230	28
28a	Miscellaneous and COVID Stimulus Revenue	2,130,451	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,130,681	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,700,082	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	709,238	31
32	Health Care	1,627,569	32
33	General Administration	521,235	33
	B. Capital Expense		
34	Ownership	221,331	34
	C. Ancillary Expense		
35	Special Cost Centers	65,694	35
36	Provider Participation Fee	201,592	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,346,659	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,353,423	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,353,423	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,980,564	44
45	Private Pay - Net Inpatient Revenue	584,350	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,564,914	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: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	735	789	$ 25,516	$ 32.34	1
2	Assistant Director of Nursing	246	246	6,500	26.42	2
3	Registered Nurses	7,293	7,412	216,372	29.19	3
4	Licensed Practical Nurses	13,658	13,996	310,979	22.22	4
5	CNAs & Orderlies	50,697	52,147	656,081	12.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,951	2,113	30,474	14.42	9
10	Activity Assistants	861	870	7,756	8.91	10
11	Social Service Workers	1,905	1,953	28,192	14.44	11
12	Dietician					12
13	Food Service Supervisor	2,277	2,333	35,025	15.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,219	12,615	118,731	9.41	15
16	Dishwashers					16
17	Maintenance Workers	1,695	1,795	28,169	15.69	17
18	Housekeepers	17,340	17,825	193,092	10.83	18
19	Laundry	1,009	1,009	11,223	11.12	19
20	Administrator	1,928	2,080	66,504	31.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,704	1,754	27,592	15.73	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	615	615	15,445	25.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	674	674	18,595	27.59	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,576	4,745	103,131	21.73	33
34	TOTAL (lines 1 - 33)	121,383	124,971	$ 1,899,377 *	$ 15.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,144	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)		$ 19,144		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,654	49,334	L10,C3	51
52	Certified Nurse Assistants/Aides	2,904	61,906	L10,C3	52
53	TOTAL (lines 50 - 52)	4,558	$ 111,240		53

Mt Vernon Health Care Center
0052290
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,964	2,001	51,884	25.93
Transportation		1,356	1,480	17,955	12.13
Alzheimer's Coordinator		1,256	1,264	33,292	26.34
	TOTAL	4,576	4,745	103,131	

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Friar	Administrator	0	$ 66,504
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,504

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 178,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 178,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Charter Communications	Computer Services	$ 840
Ability Network	Computer Services	3,896
Fifth Third Bank	Legal Filing Fees-3/16/20	48
Farmer's Insurance	Legal Filing Fees-7/14/20	28
Comerica Bank	Legal Filing Fees-12/22/20	30
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 4,842

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,667
Unemployment Compensation Insurance	26,245
FICA Taxes	138,617
Employee Health Insurance	15,079
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	100
Home Office Allocation	10,731
Administrator Benefits	13,896
TOTAL (agree to Schedule V, line 22, col.8)	$ 230,335

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	786
Health Care Worker Background Check	
(Indicate # of checks performed 19)	
Patient Background Checks 22	653
Miscellaneous Licenses & Permits	1,018
Miscellaneous Dues & Subscriptions	430
Home Office Allocation	3,228
Less: Public Relations Expense	(430)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,685

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	20
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20

**See instructions.

Mt Vernon Health Care Center
0052290
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,842
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	365
Duane Morris	Legal	7,810
Lexis Nexis	Legal	10
Livingston, Barger, Brant, Schroeder	Legal	2,783
Miller, Hall, Triggs	Legal	63
Miscellaneous	Legal	23
SB2	Legal	188
SmithAmundsen LLC	Legal	1,165
Sorling Northrup	Legal	332
Mauer and Madoff	Legal	544
Illinois Secretary of State	Legal	164
Sedgwick Claims Management	Legal	9,059
Huntington Bank	Legal	300
CliftonLarsonAllen	Accounting	7,045
Ginoli & Co.	Accounting	7,890
Ability Network	Computer Services	3,717
Allscripts	Computer Services	587
AOD Matrix Care	Computer Services	6,527
AT&T	Computer Services	7
ATS	Computer Services	356
CCH	Computer Services	21
Charter Communications	Computer Services	33
Citrix Systems	Computer Services	111
Comcast	Computer Services	38
ITSavvy	Computer Services	172
Kemper Technology	Computer Services	848
Miscellaneous	Computer Services	165
Pearl Technology	Computer Services	154
Stratus Networks	Computer Services	674
TR Professional	Computer Services	14
David Budde	Other Prof Fees	15
DJ Howard and Associates	Other Prof Fees	28
Getzler Henrich & Associates	Other Prof Fees	115
LRI Consulting Services	Other Prof Fees	112
McQuellon Consulting	Other Prof Fees	71
Miscellaneous	Other Prof Fees	132
Optimizer	Other Prof Fees	60
Registered Agent Solutions	Other Prof Fees	34
RSM McGladrey	Other Prof Fees	369
SB2	Other Prof Fees	2,736
Sedgwick CMS	Other Prof Fees	3,860
Tarver Program Consultants	Other Prof Fees	88
Total (agree to Schedule V, line 19, column 8)		63,627

Mt Vernon Health Care Center
0052290
Period Beginning **1/1/2020**
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Schedule 21B

25. Administrative and Staff Transportation

Gas	$	853
Auto Repairs		1,100
Mileage-Travel		250
Meals-Travel		88
Home Office Allocation		4,517
		6,808

Facility Name & ID Number Mt Vernon Health Care Center # 0052290 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,417** 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. $ **201,592**
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. $ **4,155**

(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. $ **230**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees.