

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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

<p>I. IDPH Facility ID Number: <u>0035998</u></p> <p>Facility Name: <u>Mount Vernon Countryside Manor</u></p> <p>Address: <u>606 New Fairfield Road</u> <u>Mt. Vernon</u> <u>62864</u> <small>Number City Zip Code</small></p> <p>County: <u>Jefferson</u></p> <p>Telephone Number: <u>(618) 242-1800</u> Fax # <u>(618) 242-1878</u></p> <p>IDPA ID Number: <u>37-1239928-1</u></p> <p>Date of Initial License for Current Owners: <u>05/09/1990</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefeller</u> Telephone Number: <u>(618) 465-7717</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>Compilation Report Attached</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Cindy A. Tefeller, Partner</u> <u>Partner</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>Compilation Report Attached</u> (Date) _____		(Print Name and Title) <u>Cindy A. Tefeller, Partner</u> <u>Partner</u>		(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

0035998 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,045</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,820</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>380</u>	<u>255</u>	<u>5,883</u>	<u>6,518</u>	8
9	SNF/PED					9
10	ICF	<u>16,194</u>	<u>10,003</u>		<u>26,197</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,574</u>	<u>10,258</u>	<u>5,883</u>	<u>32,715</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.74%

D. How many bed-hold days during this year were paid by Public Aid? 4 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 05/09/1990

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 5,883

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

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

STATE OF ILLINOIS

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	120,239	6,790	5,805	132,834		132,834		132,834		1
2	Food Purchase		125,171		125,171		125,171	(1,464)	123,707		2
3	Housekeeping	83,519	13,080		96,599		96,599	1,571	98,170		3
4	Laundry	61,850	13,784		75,634		75,634	(1,837)	73,797		4
5	Heat and Other Utilities			73,900	73,900		73,900	695	74,595		5
6	Maintenance	50,543	68,054	1,708	120,305	6,297	126,602	12,624	139,226		6
7	Other (specify):* Sanitation			3,453	3,453		3,453		3,453		7
8	TOTAL General Services	316,151	226,879	84,866	627,896	6,297	634,193	11,589	645,782		8
B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,183,029	57,025	5,541	1,245,595		1,245,595	(1,024)	1,244,571		10
10a	Therapy		278	497,256	497,534		497,534		497,534		10a
11	Activities	36,625	2,952	2,943	42,520		42,520		42,520		11
12	Social Services	35,484			35,484		35,484		35,484		12
13	Nurse Aide Training			2,469	2,469	(438)	2,031		2,031		13
14	Program Transportation		2,190		2,190		2,190		2,190		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,255,138	62,445	514,209	1,831,792	(438)	1,831,354	(1,024)	1,830,330		16
C. General Administration											
17	Administrative	61,486	6,974	195,000	263,460	(3,655)	259,805	(95,854)	163,951		17
18	Directors Fees										18
19	Professional Services			9,943	9,943		9,943	4,171	14,114		19
20	Dues, Fees, Subscriptions & Promotions			9,177	9,177	1,456	10,633	(4,417)	6,216		20
21	Clerical & General Office Expenses	38,188	13,050	9,559	60,797		60,797	40,142	100,939		21
22	Employee Benefits & Payroll Taxes			194,545	194,545	(5,676)	188,869	13,938	202,807		22
23	Inservice Training & Education					1,458	1,458		1,458		23
24	Travel and Seminar			3,098	3,098	558	3,656	196	3,852		24
25	Other Admin. Staff Transportation							1,641	1,641		25
26	Insurance-Prop.Liab.Malpractice			82,734	82,734		82,734	2,091	84,825		26
27	Other (specify):*										27
28	TOTAL General Administration	99,674	20,024	504,056	623,754	(5,859)	617,895	(38,092)	579,803		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,670,963	309,348	1,103,131	3,083,442		3,083,442	(27,527)	3,055,915		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Mount Vernon Countryside Manor

#0035998

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			119,473	119,473		119,473	8,287	127,760			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			134,861	134,861		134,861	675	135,536			33
34	Rent-Facility & Grounds			6,000	6,000		6,000	(6,000)				34
35	Rent-Equipment & Vehicles			742	742		742		742			35
36	Other (specify):*											36
37	TOTAL Ownership			261,076	261,076		261,076	2,962	264,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,040	21,237	159,277		159,277		159,277			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		138,040	76,534	214,574		214,574		214,574			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,670,963	447,388	1,440,741	3,559,092		3,559,092	(24,565)	3,534,527			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(190)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,274)	2		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				18
19	Entertainment				19
20	Contributions	(240)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,053)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,615)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,633)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,005)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(9,560)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (9,560)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (24,565)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Countryside Manor

ID# 0035998
 Report Period Beginning: 01/01/2001
 Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	2001IHCA Dues	\$ 3,050	20 1
2	2002 IHCA Dues	(5,141)	20 2
3	IHCA PAC Dues & Other Non-allowable Dues	(864)	20 3
4	Depr on Items Req'd to be Capitalized		4
5	for Cost Reporting Purposes	2,564	30 5
6	Offset Nursing Supplies Refunds	(1,024)	10 6
7	2002 IDPH License	(200)	17 7
8	Offset Insurance Reimbursement	(4,475)	6 8
9	Offset FY 01 Expenses Reimb. By Insur. In FY 02	(1,837)	4 9
10	Offset FY 01 Expenses Reimb. By Insur. In FY 02	(2,893)	6 10
11	Offset FY 01 Expenses Reimb. By Insur. In FY 02	(13)	17 11
12	Record 2001 IDPH License	200	20 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	(10,633)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,464)	0	0	0	0	0	0	0	0	0	0	(1,464)	2
3	Housekeeping	0	1,571	0	0	0	0	0	0	0	0	0	1,571	3
4	Laundry	(1,837)	0	0	0	0	0	0	0	0	0	0	(1,837)	4
5	Heat and Other Utilities	0	695	0	0	0	0	0	0	0	0	0	695	5
6	Maintenance	(7,368)	19,992	0	0	0	0	0	0	0	0	0	12,624	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,669)	22,258	0	11,589	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	(1,024)	0	0	0	0	0	0	0	0	0	0	(1,024)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	(1,024)	0	0	0	0	0	0	0	0	0	0	(1,024)	16
	C. General Administration													
17	Administrative	(213)	(95,641)	0	0	0	0	0	0	0	0	0	(95,854)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,053)	5,224	0	0	0	0	0	0	0	0	0	4,171	19
20	Fees, Subscriptions & Promotions	(4,610)	193	0	0	0	0	0	0	0	0	0	(4,417)	20
21	Clerical & General Office Expenses	0	40,142	0	0	0	0	0	0	0	0	0	40,142	21
22	Employee Benefits & Payroll Taxes	0	13,938	0	0	0	0	0	0	0	0	0	13,938	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	196	0	0	0	0	0	0	0	0	0	196	24
25	Other Admin. Staff Transportation	0	1,641	0	0	0	0	0	0	0	0	0	1,641	25
26	Insurance-Prop.Liab.Malpractice	0	2,091	0	0	0	0	0	0	0	0	0	2,091	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,876)	(32,216)	0	(38,092)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,569)	(9,958)	0	(27,527)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998

Report Period Beginning:

01/01/2001 Ending:12/31/2001

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	2,564	5,723	0	0	0	0	0	0	0	0	0	8,287 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	675	0	0	0	0	0	0	0	0	0	675 33
34	Rent-Facility & Grounds	0	0	(6,000)	0	0	0	0	0	0	0	0	(6,000) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	2,564	6,398	(6,000)	0	2,962 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(15,005)	(3,560)	(6,000)	0	(24,565) 45							

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00%	Aviston Nursing Center, Inc. d/b/a Countryside Manor	Aviston	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00%	King-Taylorville, Inc. d/b/a Taylorville Care Center	Taylorville			
Jerry & Marilyn King	100.00%	King Management, Inc. d/b/a Nokomis Golden Manor	Nokomis			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 See Schedule VIII	\$	King Management Co.	100.00%	\$ 1,571	\$ 1,571 1
2	V	5 See Schedule VIII		King Management Co.	100.00%	695	695 2
3	V	6 See Schedule VIII		King Management Co.	100.00%	19,992	19,992 3
4	V	17 See Schedule VIII	195,000	King Management Co.	100.00%	99,359	(95,641) 4
5	V	19 See Schedule VIII		King Management Co.	100.00%	5,224	5,224 5
6	V	20 See Schedule VIII		King Management Co.	100.00%	193	193 6
7	V	21 See Schedule VIII		King Management Co.	100.00%	40,142	40,142 7
8	V	22 See Schedule VIII		King Management Co.	100.00%	13,938	13,938 8
9	V	24 See Schedule VIII		King Management Co.	100.00%	196	196 9
10	V	25 See Schedule VIII		King Management Co.	100.00%	1,641	1,641 10
11	V	26 See Schedule VIII		King Management Co.	100.00%	2,091	2,091 11
12	V	30 See Schedule VIII		King Management Co.	100.00%	5,723	5,723 12
13	V	33 See Schedule VIII		King Management Co.	100.00%	675	675 13
14	Total		\$ 195,000			\$ 191,440	\$ * (3,560) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
15	V	34 Land Lease	\$ 6,000	Jerry King		\$	\$ (6,000)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,000			\$ 0	\$ * (6,000)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00%	168,379	16	26.25%	Salary	\$ 59,916	17,8	1
2	Denise King	Regional Director	Administrative	0.00%	101,606	13	26.25%	Salary	36,156	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00%	54,789	13	26.25%	Salary	19,496	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00%	97,630	0	0.00%	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00%	2,400	0	0.00%	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00%	2,213	1	26.25%	Salary	787	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 116,355		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization King Management Company
 Street Address 935 Mill Street
 City / State / Zip Code Nashville, Illinois 62263
 Phone Number (618) 327-3064
 Fax Number (618) 327-3083

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	3	Housekeeping	Patient Days	124,610	4	\$ 5,984	\$ 5,984	32,704	\$ 1,571	1
2	5	Utilities	Patient Days	124,610	4	2,650	32,704	695		2
3	6	Maintenance	Patient Days	124,610	4	76,174	74,286	32,704	19,992	3
4	17	Administrative	Patient Days	124,610	4	378,582	369,057	32,704	99,359	4
5	19	Professional Fees	Patient Days	124,610	4	19,903	32,704	32,704	5,224	5
6	20	Dues, Fees & Subscriptions	Patient Days	124,610	4	735	32,704	32,704	193	6
7	21	Clerical & Office Expense	Patient Days	124,610	4	152,952	118,721	32,704	40,142	7
8	22	Employee Benefits	Patient Days	124,610	4	53,108	32,704	32,704	13,938	8
9	24	Travel & Seminar	Patient Days	124,610	4	745	32,704	32,704	196	9
10	25	Other Admin Transport.	Patient Days	124,610	4	6,252	32,704	32,704	1,641	10
11	26	Insurance	Patient Days	124,610	4	7,969	32,704	32,704	2,091	11
12	30	Depreciation - Other	Patient Days	124,610	4	8,640	32,704	32,704	2,268	12
13	30	Depreciation - Vehicle	Direct Cost	1	1	969	1	1	969	13
14	30	Depreciation - Vehicle	Patient Days	124,610	4	5,518	32,704	32,704	1,448	14
15	30	Depreciation - Copier	Direct Cost	1	1	1,038	1	1	1,038	15
16	33	Property Taxes	Patient Days	124,610	4	2,571	32,704	32,704	675	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 723,790	\$ 568,048		\$ 191,440	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Schedule Not Applicable						\$	\$			\$	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$	\$			\$	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$	\$			\$	15						

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Mount Vernon Countryside Manor**# **0035998** Report Period Beginning: **01/01/2001** Ending: **12/31/2001****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 2000 report.			\$	3,250	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.)			\$	67,371	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	64,121	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	70,740	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 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	134,861	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	2,863	8	FOR OHF USE ONLY	
		1997	2,966	9		
		1998	3,080	10	13	FROM R. E. TAX STATEMENT FOR 2000 \$
		1999	3,115	11		
		2000	67,371	12	14	PLUS APPEAL COST FROM LINE 5 \$
Line 2: Real Estate Taxes paid for the 2000 tax year		Line 7: \$ 134,861 Real Estate Tax Expense				
Line 4: Accrual is based on 2000 taxes paid		675 Home Office Allocation		15	LESS REFUND FROM LINE 6	\$
		\$135,536 Total Real Estate Tax				
				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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount Vernon Countryside Manor COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0035998

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>56-2-789-02</u>	<u>LMC Plaza - Lots 1 thru 5</u>	\$ <u>67,371.16</u>	\$ <u>67,371.16</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>67,371.16</u>	\$ <u>67,371.16</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998 Report Period Beginning:01/01/2001 Ending:12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories OneC. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

Residential Living Center is a 37 unit, 28,000 square foot retirement center located on the property adjacent to Mount Vernon Countryside Manor.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 95,254	1
2	Home Office		1989 & 1995	1,651	2
3	TOTALS			\$ 96,905	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998

Report Period Beginning:

01/01/2001 Ending: 12/31/2001**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	101		1990	1990	\$ 2,725,128	\$ 90,838	30	\$ 90,838	\$	\$ 1,059,657	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Landscaping	1990		26,544		10			26,544	9
10		Parking Lot	1990		26,563		10			26,563	10
11		Door and Screen	1992		1,700		10	170	170	1,615	11
12		Vanity and Medicine Cabinet	1992		1,136		10	114	114	1,079	12
13		Garage	1993		7,238	483	15	483	114	4,062	13
14		Water Heater	1995		2,960	197	15	197		1,315	14
15		Smoke Detectors	1996		812	81	10	81		487	15
16		Air Conditioners - 2	1996		1,342	45	5	45		1,342	16
17		Multiflow Furnace/Condensing Unit	1996		1,541	154	5	154		1,541	17
18		Storage Building Roof	1996		5,100	510	10	510		2,890	18
19		Asphalt East Parking Lot	1996		2,373	237	10	237		1,305	19
20		Air Conditioners - 2	1996		1,549	258	5	258		1,549	20
21		Entry Control System	1996		1,133	113	10	113		680	21
22		Vinyl Floor Covering	1996		4,465	447	10	447		2,456	22
23		Fire Alarm System	1997		13,564	904	15	904		4,295	23
24		Furnace and Tempering Valve	1997		2,112	141	15	141		681	24
25		2 Air Conditioners	1997		1,502	150	10	150		676	25
26		Water Heater	1998		3,273	218	15	218		873	26
27		Air Freshener System	1998		1,314	132	10	132		515	27
28		Air Freshener System	1998		1,300	130	10	130		444	28
29		Gazebo	1998		2,974	198	15	198		694	29
30		Water Heater	1999		3,414	228	15	228		588	30
31		Water Heater	1999		2,429	162	15	162		418	31
32		Carpet	2000		9,666	967	10	967		1,128	32
33		Flooring	2000		18,661	1,866	10	1,866		2,022	33
34		Concrete Pad for Gazebo	2000		4,303		15	287	287	454	34
35		Landscaping	2001		7,305	365	10	365		365	35
36		Electrical Repairs	2001		6,691	557	10	557		557	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Water Heater	2001	\$ 2,745	\$ 183	15	\$ 183	\$	\$ 183	37
38	Cabinets	2001	28,181	1,174	20	1,174		1,174	38
39									39
40									40
41	Home Office Parking Lot	1989	519					519	41
42	Home Office New Building	1995	25,728		25	1,029	1,029	6,346	42
43	Home Office Interior Finishes	1996	1,596		15	106	106	585	43
44	Home Office Carpet	1996	558		5	56	56	558	44
45	Home Office Cabinets	1996	883		20	44	44	243	45
46	Home Office Electrical	1996	306		15	20	20	112	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)		\$ 2,948,608	\$ 100,738		\$ 102,564	\$ 1,826	\$ 1,156,515	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 118,268	\$ 10,584	\$ 14,316	\$ 3,732	4-10	\$ 58,063	71
72	Current Year Purchases	49,793	3,976	4,288	312	5	4,288	72
73	Fully Depreciated Assets	397,013					397,013	73
74								74
75	TOTALS	\$ 565,074	\$ 14,560	\$ 18,604	\$ 4,044		\$ 459,364	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1993 Dodge Caravan	1993	\$ 15,738	\$	\$	\$	4	\$ 15,738	76
77	Facility	1998 Ford F150 Truck	1997	6,951		1,448	1,448	4	6,951	77
78	Home Office Vehicle	1999 Ford Escort	1999	Disposed in '01		969	969			78
79	Facility	2000 Chevy LS Van w/lift	2001	22,659	4,175	4,175		4	4,175	79
80	TOTALS			\$ 45,348	\$ 4,175	\$ 6,592	\$ 2,417		\$ 26,864	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)	\$ 3,655,935	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,473	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 127,760	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,287	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,642,743	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	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? N/A YES NO
 16. Rental Amount for movable equipment: \$ 742 Description: Dishwasher

(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	<u>Section Not Applicable</u>		\$	\$	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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 948	\$ 633	\$	\$ 1,581
2	Books and Supplies	213	127		340
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		110		110
9	TOTALS	\$ 1,161	\$ 870	\$	\$ 2,031
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,031			

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	5

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$	7,584	\$	148,196	\$	7,584	\$	148,196	1		
2	Licensed Speech and Language Development Therapist	10a,3	hrs		5,241		122,390		5,241		122,390	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a,3 & 10a,2	hrs		11,302		226,670		11,302	278	226,948	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 prescripts							138,040	138,040	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify): Lab, X-Ray & Ambulance	39,3								21,237	21,237	13		
14	TOTAL			\$	24,127	\$	497,256	\$	159,555		24,127	\$	656,811	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 675,640	\$	1
2 Cash-Patient Deposits	5,900		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 20,012)	840,706		3
4 Supply Inventory (priced at cost)	9,202		4
5 Short-Term Investments			5
6 Prepaid Insurance	72,920		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Utility Deposit	250		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,604,618	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost	2,911,879		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	550,864		16
17 Accumulated Depreciation (book methods)	(1,586,048)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	54,018		19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(54,018)		20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,876,695	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,481,313	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 181,141	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	5,900		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	116,909		30
31 Accrued Taxes Payable (excluding real estate taxes)	12,254		31
32 Accrued Real Estate Taxes(Sch.IX-B)	70,740		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Related Party Payable</u>	7,750		36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 394,694	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 394,694	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 3,086,619	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,481,313	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,040,297	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,040,297	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	727,113	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	(680,791)	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)	\$ 46,322	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)	\$ 3,086,619	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,125,211	1
2	Discounts and Allowances for all Levels	351,677	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,476,888	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	696,793	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 696,793	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	79,414	19
20	Radiology and X-Ray	20,949	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 100,363	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,898	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,898	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	10,263	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,263	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,286,205	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	627,896	31
32	Health Care	1,831,792	32
33	General Administration	623,754	33
B. Capital Expense			
34	Ownership	261,076	34
C. Ancillary Expense			
35	Special Cost Centers	159,277	35
36	Provider Participation Fee	55,297	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,559,092	40
41	Income before Income Taxes (line 30 minus line 40)**	727,113	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 727,113	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Mount Vernon Countryside Manor**

0035998

Report Period Beginning: **01/01/2001**

Ending:

12/31/2001

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	1,828	2,162	\$ 44,288	\$ 20.48	1
2	Assistant Director of Nursing	1,940	2,145	34,989	16.31	2
3	Registered Nurses	11,894	12,652	199,466	15.77	3
4	Licensed Practical Nurses	20,675	21,864	272,333	12.46	4
5	Nurse Aides & Orderlies	73,482	77,240	631,954	8.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,929	5,311	36,625	6.90	10
11	Social Service Workers	3,906	4,100	35,484	8.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,076	16,726	120,239	7.19	15
16	Dishwashers					16
17	Maintenance Workers	3,601	3,780	50,543	13.37	17
18	Housekeepers	11,726	12,169	83,519	6.86	18
19	Laundry	9,720	9,794	61,850	6.32	19
20	Administrator	1,852	2,321	46,125	19.87	20
21	Assistant Administrator	1,260	1,355	15,360	11.34	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,885	4,300	38,188	8.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,774	175,919	\$ 1,670,963 *	\$ 9.50	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	143	\$ 5,805	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	20	910	10,3	37
38	Nurse Consultant	Contract	210	10,3	38
39	Pharmacist Consultant	Contract	1,000	10,3	39
40	Physical Therapy Consultant	Contract	3,421	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	2,943	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	219	\$ 20,289		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ Section Not Applicable	50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998Report Period Beginning: 01/01/2001Ending: 12/31/2001

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. Illinois Health Care Association - \$3781
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,456 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 55,297
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (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. \$ None Has any meal income been offset against related costs? None-N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 57%
- 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? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

MOUNT VERNON COUNTRYSIDE MANOR
RECLASSIFICATIONS
12/31/01

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	1,456
TRAVEL & SEMINAR	24	1,578
EMPLOYEE BENEFITS	22	621
ADMINISTRATIVE	17	(3,655)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
DUES & LICENSES	\$ (459)	
EMPLOYEE PARTIES	(621)	
SUBSCRIPTIONS	(373)	
SEMINARS	(1,578)	
BACKGROUND CHECKS	(624)	
TOTAL	<u>(3,655)</u>	
MAINTENANCE	6	6,297
EMPLOYEE BENEFITS	22	(6,297)
TO RECLASS EMPLOYEE UNIFORMS		
INSERVICE TRAINING & EDUCATION	23	438
NURSE AIDE TRAINING	13	(438)
TO RECLASS SEMINARS		
INSERVICE TRAINING & EDUCATION	23	1,020
TRAVEL & SEMINAR	24	(1,020)
TO RECLASS TRAINING		

K & G, INC. D/B/A/ MT. VERNON COUNTRYSIDE MANOR
IDPH ID #0035998
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/01

OTHER REVENUE:

BEAUTY SHOP INCOME	\$400
TRANSPORTATION	330
INSURANCE REIMBURSEMENT	4,475
FOOD REBATES	190
MEDICARE COST REPORT ADJUSTMENT	2,849
MEDICAL SUPPLIES REIMBURSEMENT	1,024
CNA TRAINING REIMBURSEMENT	529
INTEREST	356
MISCELLANEOUS	110
	<u>10,263</u>

MT. VERNON COUNTRYSIDE MANOR
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2001

NAME OF PERSONS ATTEND	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST
		3/28-3/29 &				
Peggy Coon	Activity Director	4/25-4/26	Mt. Vernon	36 Hour Basic Orientation Course for New Activity Directors	Ramirez Consulting	500
Madelyn Watso	Social Services	3/8/2001	Springfield	SSPI 6th Annual Convention - Our Care is Timeless	SSPI	72
Keisha Smith	Care Plan	3/20/2001	Mt. Vernon	MDS Basics ... and Beyond	IHCA	85
Kerry Maier	Social Services	3/20/2001	Mt. Vernon	MDS Basics ... and Beyond	IHCA	65
Peggy Coon	Activity Director	3/20/2001	Mt. Vernon	MDS Basics ... and Beyond	IHCA	65
Kay Carter	Medicare Coord.	3/16/2001	Springfield	Set Sail: Facilitator Software Training and The Right Way to Qua	IHCA	125
Keisha Smith	Care Plan	3/16/2001	Springfield	Set Sail: Facilitator Software Training and The Right Way to Qua	IHCA	110
					Southern IL Dietary Mgrs.	
Dana Fults	Dietary Manager	4/6/2001	Pinckneyville	Southern District Spring Meeting	Assn	25
Dana Fults	Dietary Manager	5/1/2001	Rend Lake	Achieving Survey Success in Dietary and Nutritional Services	IHCA	85
Kay Carter	Medicare Coord.	6/26/2001	Mt. Vernon	MDS Advanced	IHCA	85
Keisha Smith	Care Plan	6/26/2001	Mt. Vernon	MDS Advanced	IHCA	65
Denise King	Regional Director	7/12/2001	Mt. Vernon	The Anatomy of a Nursing Home Malpractice Action	IHCA	85
Keisha Smith	Care Plan	10/10/2001	Mt. Vernon	MDS ... by the Book	IHCA	85
Charlotte Shaw	Care Plan Coord.	10/10/2001	Mt. Vernon	MDS ... by the Book	IHCA	65
Denise King	Regional Director	10/10/2001	Mt. Vernon	MDS ... by the Book	IHCA	65
Sondra K. Jame	Dietary	11/26/2001	Mt. Vernon	Refresher Course for Food Handlers	U of I Extension	50
Peggy Coon	Activities	10/4-10/5	Decatur	Activity Convention	IAPA	160
Davina Schreiber	Activities	10/4-10/5	Decatur	Activity Convention	IAPA	160
				Pharmacy Rehab Convention		120
				IHCA Convention	IHCA	1,146
				Travel/Lodging IHCA Convention		265
				Miscellaneous Seminar Travel		6
				Travel/Lodging Activities Convention		167
						3,656